Audit Report

Cigna

January 1, 2013 – December 31, 2013

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
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LEGISLATIVE AUDIT DIVISION

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April 2014

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of Cigna for medical insurance claims for the State of Montana employee benefits plan for the plan year ended December 31, 2013.

The audit was conducted by Claim Technologies Incorporated under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor

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The agency's written response to the report is included in the back of the audit report.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

13C-09

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COMPREHENSIVE CLAIMS ADMINISTRATION AUDIT

EXECUTIVE SUMMARY

State of Montana

Administered by: Cigna
Audit Period: January 1, 2013 to December 31, 2013

Presented to:

State of Montana

April 28, 2014

Private and Confidential

Presented by:
Claim Technologies Incorporated

Preface

This Executive Summary consolidates important findings from each of the four separate components of Claim Technologies Incorporated's (CTI's) comprehensive audit of Cigna's claims administration of the State of Montana (the State's) self insured Medical plan.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Cigna, and CTI in their efforts to serve the interests of the plan participants of the State of Montana Medical Plan. This report is based on data and information provided to CTI by the State and Cigna. CTI's compilations and findings rely upon the accuracy and completeness of that information and the samplings taken from it.

CTI is a firm specializing in audit and control of health plan claims administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of Cigna's claims process and systems and to the accuracy and validity of the State's paid claims during the audit period.

We conducted our audit in accordance with standards and procedures generally accepted and in common practice for Medical plan claims audits in the insurance industry of the United States.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

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Key Findings

Comprehensive Claim Administration Audit of State of Montana Medical Plans by Cigna

Audit Period: **January 1, 2013 to December 31, 2013**

CTI's Comprehensive Audit of Cigna's claims administration of the State of Montana Medical Plan for the above-stated period included four components: 1) Operational Review; 2) Plan Documentation Review; 3) Electronic Screening; and 4) Random Sample Audit. Presented here are Key Findings from the audit as a whole. Supporting detail for the findings, conclusions, and recommendations herein can be found in the Specific Findings Report (provided separately).

CTI's Random Sample Audit component included review of claims selected from those paid during the period of January 1, 2013 to December 31, 2013. Based on this sample, we compared Cigna's performance with that of approximately 100 other plans audited by CTI over the past 16 months. Of the six Key Performance Indicators[1] for which CTI has developed benchmarks to measure and monitor claims payment accuracy and administrative process quality Cigna's performance was above the median in five and below average in one. Performance Indicators that may be of special interest to the State include:

- **Financial Accuracy,** as demonstrated in the Random Sample Audit, was 96.91%, which is below median as compared to other plans audited by CTI. Imputed to the annualized $89.4 million in claims paid during the 12-month audit period, the 3.09% financial error rate equates to $2.76 Million in errors compared to best in practice performance. Three of the four claims in which CTI cited errors related to coordination of benefits with Medicare or other private insurance.
- **Accurate Payment Frequency,** as demonstrated in the Random Sample Audit, was 97.78%, meaning Cigna paid 7,299 claims in error during the audit period. As noted above, the State has a large number of participants eligible for Medicare. Two of the four errors cited related to inaccurate coordination with Medicare and the other was due to incorrect coordination with other private insurance.

The seventh Key Performance Indicator used by CTI, Claim Turnaround Time, is evaluated by looking at the distribution of turnaround times for claims in the audit sample; through this evaluation Cigna's claim turnaround time of 11 calendar days requires improvement.

In addition to its random sample audit, CTI employed its proprietary electronic screening system to screen 100% of the services processed by Cigna during the audit period. It should be noted that CTI intentionally sets its screening parameters conservatively to limit the number of false positives. Electronic screening results are reported for specific control

[1] Financial Accuracy, Accurate Payment Frequency, Adjudication Proficiency, Accurate Processing Frequency, Documentation Accuracy Financial and Documentation Accuracy Frequency (operational Definitions for each indicator can be found in Exhibit A of this report.

risk categories. The dollar amounts associated with each category represent potential, not substantiated, overpayments.

Based on Cigna's self-reported results through November 2013 (final results for the entire calendar year were not available at the time of CTI's audit), Cigna performed above its contractual performance guarantee of 98% for claim accuracy for each of the first three calendar quarters of 2013. In two of those quarters, Cigna performed more than 1.5% above the required level of performance to avoid a penalty. CTI independently calculated financial accuracy using the errors found in our Random Sample Audit, but using the definition in the State's Administrative Agreement with Cigna. Based on CTI's calculation, Cigna's financial accuracy was 98.85% for calendar year of 2013. CTI observes that a performance guarantee level of 98% for claim accuracy means that based on the $89 million in claims paid during 2013, Cigna could make errors (both underpayments and overpayments) in excess of $1.7 million and still meet its contractual guarantees to the State.

CTI and Cigna do not determine financial accuracy through identical calculations. Among the differences in approach is that Cigna does not count as an error any claim that was adjusted as the result of its internal quality assurance process. Because of CTI's focus on continuous quality improvement, CTI counts errors based on the initial processing of the claim. CTI believes that it is important for an administrator to conduct causal analysis of errors to determine their root cause and to systematically identify all other claims affected and to perform remediation. This may not always occur with correction of the single claim reviewed as the result of internal quality insurance.

Cigna's self-reported results also demonstrated that with the exception of claim processing time, all contracted performance guarantees were achieved. Cigna indicated a credit would be issued to the State related to performance below the contracted level for claim processing time.

Overpayment recovery or process improvement, to the extent the State wishes to pursue them, should be discussed with Cigna with specific goals, timing and reporting agreed upon. CTI's comprehensive audit fee includes 10 hours of post-audit time to provide the State with further assistance regarding any issues.

Cigna made every effort to cooperate with this audit and was able to provide CTI with the data and documentation that we requested.

Recommendations based on the foregoing are presented on page 16 of this report.

Comprehensive Audit Methodology

Audit Objectives

The specific objectives of CTI's comprehensive audit of Cigna's claims administration of the Medical benefits for persons insured through the State's Medical Plan for the audit period were to:

- Evaluate the overall effectiveness and security of Cigna's claims payment and eligibility maintenance systems and processes;
- Determine if claims processed during the audit period were adjudicated according to the Plan Document/Summary Plan Description that govern the administration of claims and benefits;
- Determine if Cigna is fully and consistently performing services according to the in-force Administrative Services Agreement;
- Identify payment errors, including overpayments for possible recovery; and,
- Identify and address the causes of errors to address and prevent their recurrence in the future.

Audit Scope

The scope of the comprehensive audit included all State of Montana Medical claims paid or denied during the 12 months beginning 1/1/2013. Cigna paid or denied 331,817 Medical claims (including adjustments) resulting in $89,413,284 in total payment during this period.

To achieve the specific audit objectives stated above, CTI's audit included the following components:

I.	**Operational Review** ➢ **Operational Review Questionnaire Completed by Claims Administrator**
II.	**Plan Documentation Review** ➢ **Evaluation of Plan Documents/Summary Plan Descriptions, Administrative Services Agreement, Reinsurance Agreement (if applicable)** ➢ **Clarification of "Gray Areas" in Plan Documents/Summary Plan Descriptions** ➢ **Preparation of Plan Benefit Matrices for Use Audit**
III.	**Electronic Screening** ➢ **Electronic Screening of 100% of Paid Claims for the audit period using ESAS®** ➢ **Problem Identification In Proven Control Risk Categories** ➢ **Identification of Recovery/Savings Potential** ➢ **Identification of Potentially Costly Procedural and System Problems**
IV.	**Random Sample Audit** ➢ **Stratified Random Sample of 180 Medical Claims Paid or Denied** ▪ **Statistical Confidence level of 95%, with a 3% margin of error** ➢ **Error Identification by Type and Frequency** ➢ **Verification of Eligibility**

Comprehensive Audit Results

Operational Review

Operational Review Scope

CTI conducted an operational review of Cigna to evaluate the systems, staffing and procedures related to claims administration, including eligibility maintenance, enrollment, customer service, appeals processing and fraud, waste and abuse control. Specifically, we reviewed these aspects of Cigna's administration to observe any deficiencies that might materially affect their ability to control risk and pay claims on behalf of the State.

Operational Review Methodology

CTI gathered information from Cigna through the use of a four-part questionnaire called the "Operational Review Questionnaire." The questionnaire is modeled after the audit tool used by CPA firms when they conduct an SAS-70 (now the SSAE-16) audit of a service administrator. CTI modified the questionnaire to request more information than the SSAE-16 typically requires, but also to attain information specific to Cigna's administration of the State's plan, rather than its overall book of business.

Finally, CTI used its proprietary electronic screening software to identify and select a targeted sample of cases from the claims processed by Cigna to test certain key processes that affect a small number of claims, but have a high payment potential. These included large dollar claims, high risk diagnoses and procedures, and accident cases with the potential for subrogation recovery.

Operational Review Findings

CTI's Operational Review concluded that:

- Cigna has complied with the standards of the American Institute of Certified Public Accounts (AICPA) through issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization, which replaces the prior SAS 70 Report. Under SSAE 16, Cigna is required to provide its own description of its system, which the service auditor validates. Cigna's external auditor, PricewaterhouseCoopers LLP, did not note any deviations in the Eligibility and Enrollment, Claims, and Financial Services Controls.
- Cigna states they maintain a $50 million Fidelity Bond; however, copies of the policy face pages were not provided to CTI for verification.
- Cigna provided its self-reported results for measures subject to various performance guarantees through November 2013. Results for calendar year 2013 were not available at the time Cigna responded to CTI's questionnaire. CTI notes, however, that the performance guarantee for claim accuracy is

98%. In two of the calendar quarters for which results were available, Cigna exceeded this goal by more than 1.5%. The State may wish to consider revising the goal upward at the time the contract is renegotiated to provide Cigna a more challenging goal for guaranteed performance.

- CTI notes that the performance measure for determining acceptable financial accuracy is 98%. Based on the State's annual paid claims of more than $89 million, Cigna could make errors of up to $1.7 million per year and still meet the performance guarantee. Performance also is measured at the "Office Level" meaning results reported are not unique to the State's claims. The State may wish to consider revising the goal upward at the time the contract is renegotiated to provide Cigna a more challenging goal for guaranteed performance.
- The State is supported by a dedicated account team of eight customer service associates who have median tenure at Cigna of seven years. This team has the capability to provide excellent service to the State.
- Cigna has appropriate levels of security and control within its claim funding and check issuance procedures to protect State interests and to ensure that transactions are performed by only authorized personnel.
- Cigna uses pre-payment high dollar claim review procedures for claims above specified dollar amounts based on processor experience. Designated high dollar processors review claims over $99,999.99. Claim payments in excess of $250,000 are reviewed by a quality panel with representatives from all departments.
- Cigna credits refunds to State claims account. All refunds are processed using the gross recovery amount. As refunds are processed in the claim system, the entire amount of the refund is credited back to the client through the normal banking process and is documented on the policyholder's monthly check register.
- Cigna has adequately documented training, workflow, procedures and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Cigna attempts to keep coordination of benefits information current by soliciting other insurance information on a rolling 12 month basis. When other insurance information is unknown and the claim is under $500, Cigna will pay the claim and request other insurance information from the insured. If the payable amount exceeds $500, the claim is pended and other insurance information is requested from the insured. The claim will deny if no response is received within 90 days of the request. This procedure provides assurance to the State that Cigna is actively investigating and pursuing the existence of other medical coverage to avoid primary liability when appropriate.
- Cigna uses the maximum reimbursable charge, option 2 (MRC2) to limit out-of-network charges. The MRC2 fee schedule is developed by Cigna and is based on a methodology similar to that used by the Centers for Medicare and

Medicaid Services (CMS) to determine fees for services within a geographic market. This method of reimbursement is designed to limit overall charges to client such as the State.

- Cigna recertifies disabled dependents on an annual basis. If documentation is not provided to support the disability, individuals affected are terminated after 90 days. This process ensures that only those dependents who are truly disabled are kept on their parents' coverage.
- Cigna does not pursue overpayments less than $50, which is a higher threshold than used by most other administrators, based on CTI's experience. The State may wish to request a listing of low dollar overpayments to determine if this threshold is adequate.
- Cigna has appropriate levels of security and controls in place to protect State plan records and data and is compliant with HIPAA requirements.
- Cigna is compliant with all required HIPAA compliant electronic transactional requirements.

Correct Coding Initiatives

As a component of its comprehensive audit, CTI reports on The Centers for Medicare & Medicaid Services (CMS) mandates regarding several initiatives that prevent improper payments of Medicare Part B and Medicaid claims. The overall goal of the initiatives is to reduce payment errors by identifying and addressing billing errors made by providers.

The two CMS initiatives that can provide the greatest benefit to employee benefit plan managers of self-funded plans are the:

- Procedure-to-Procedure Edits, and
- Medically Unlikely Edits (MUEs).

CTI has retrospectively identified potential overpayments for the medical plans being audited as if the CMS guidelines had been utilized. These reports also can be used to help employers evaluate the strength of their administrator's prepayment claim review methodologies.

The Procedure-to-Procedure Edits compare procedure codes from multiple claim lines on the same day. These CMS edits dictate when procedures from multiple lines of a claim cannot be billed together.

Medical Unlikely Edits (MUEs) are designed to limit fraud and/or coding errors. The MUE rule for a given CPT/HCPCS code is the maximum number of service units that a provider should report for a single day of service. An MUE is defined as an edit that tests claim lines for the same beneficiary, procedure code, date-of-service, and billing provider against a maximum allowable number of service units.

Electronic screening of all service lines processed revealed certain service lines to have potentially been incorrectly coded according to the guidelines provided by CMS. Following are CTI's NCCI Procedure-to-Procedure Edit Reports for procedure code combinations with greater than $3,000 in potential overpayments:

Procedure to Procedure Edits

greater than $3,000 paid
Based on Paid Dates 01/01/2013 thru 12/31/2013

Outpatient Hospital Services (facility claims with codes not designated inpatient)

Primary		Secondary						
Code	Modifier	Code	Modifier	Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
					none			

Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)

Primary		Secondary						
Code	Modifier	Code	Modifier	Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
45385		45380	51	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	74	$25,269
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	57	$10,784
29806	SG	29807	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	3	$9,478
93505	26	93451	26	YES	BIOPSY OF HEART LINING	RIGHT HEART CATH	6	$7,290
75894	26	36005	51	YES	X-RAYS TRANSCATH THERAPY	INJECTION EXT VENOGRAPHY	14	$7,066
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONEN	PREV VISIT EST AGE 1-4	44	$6,785
98940		97140		YES	Chiropract manj 1-2 regions	Manual therapy 1/> regions	159	$6,357
22633		63047	51	YES	LUMBAR SPINE FUSION COMBINE	Remove spine lamina 1 lmbr	4	$6,333
90471		99213		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	58	$6,320
90471		99214		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	34	$5,485
36224		36222	51	YES	Place cath carotd art	Place cath carotid/inom art	4	$5,367
31267	SG	31256	SG	YES	ENDOSCOPY MAXILLARY SINUS	EXPLORATION MAXILLARY SINUS	3	$4,947
90460		99391		YES	IM ADMIN 1ST/ONLY COMPONEN	Per pm reeval est pat infant	33	$4,723
90471		99392		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 1-4	31	$4,649
22630		63047	51	YES	LUMBAR SPINE FUSION	Remove spine lamina 1 lmbr	3	$4,512
90471		99391		YES	IMMUNIZATION ADMIN	Per pm reeval est pat infant	33	$4,481
63047	51	63042	51	YES	Remove spine lamina 1 lmbr	LAMINOTOMY SINGLE LUMBAR	2	$4,185
29824	SG	29822	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	1	$3,655
97140	GP	97530	GP	YES	Manual therapy 1/> regions	THERAPEUTIC ACTIVITIES	71	$3,646
98941		97140		YES	Chiropract manj 3-4 regions	Manual therapy 1/> regions	101	$3,618
28299	SG	28270	SG	YES	CORRECTION OF BUNION	RELEASE OF FOOT CONTRACTURE	1	$3,424
28299	SG	28285	SG	YES	CORRECTION OF BUNION	REPAIR OF HAMMERTOE	3	$3,424
29824	51	29822	51	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	3	$3,331
29806	SG	29823	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	1	$3,320
72149		72148		NO	MRI LUMBAR SPINE W/DYE	MRI LUMBAR SPINE W/O DYE	1	$3,141
29827	81	29822	81	YES	ARTHROSCOP ROTATOR CUFF REP	SHOULDER ARTHROSCOPY/SURGER	2	$3,077
						TOTAL over $3,000	**746**	**$154,664**
						GRAND TOTAL	**2,297**	**$370,336**

From these limited reports, more than $150,000 in payments in excess of $3,000 has been allowed for secondary procedures that would not have been allowed by CMS (Medicare or Medicaid). Furthermore, there is more than $220,000 of disallowed procedures (with less than $3,000 of potential overpayments) also identified but not detailed in this report.

Following are CTI's NCCI MUE Edit Reports for procedure code combinations in total and with greater than $1,000 in potential overpayments:

MUE Edits

Greater than $1000 paid

Based on Paid Date 01/01/2013 thru 12/31/2013

Outpatient Hospital Services (facility claims with codes not designated inpatient)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
		none		

Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
88331	11	PATH CONSULT INTRAOP 1 BLOC	1	$2,223
		TOTAL OVER $1,000	**1**	**$2,223**
		GRAND TOTAL	**98**	**$11,339**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, and Non-Facility)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
		none		

It is difficult to establish the extent to which administrators and carriers are using NCCI edits as they are only mandated for Medicare and Medicaid Payers. However, CTI recommends that these reports be discussed with Cigna to determine the extent that CMS edits could be used. Use of these edits would result in a reduction of claim expenses for employers and their employees, as well as furthering efforts toward a standardized code-editing system for all payers.

PPO Network Utilization and Savings

As a component of its comprehensive audit, CTI reports on the value of discounts given by Network providers as a percentage of all claims processed during the audit period.

According to the data received, during the audit period, Cigna achieved 20.2% off billed charges as a discount on in-network claims. CTI observed several in-network claims that were paid at billed charge and when tested, Cigna responded that the claims were paid correctly as the provider was billing at or below the contracted rate.

The next page includes the result of that analysis using the Cigna claim data provided for this audit:

Claim Technologies Incorporated
Provider Discounts for Montana State - CIGNA
Based on Paid Date 01/01/2013 thru 12/31/2013

Total of All Claims

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$4,217,951	$688,938	16.3%	$2,480,775
Non-Facility	$57,199,264	$16,062,286	28.1%	$30,457,183
Facility Inpatient	$32,897,333	$6,625,921	20.1%	$23,483,608
Facility Outpatient	$46,453,489	$5,273,563	11.4%	$32,991,717
Total	**$140,768,038**	**$28,650,708**	**20.4%**	**$89,413,284**

In-Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$3,595,071	$535,652	14.9%	$2,222,320
Non-Facility	$55,248,863	$15,425,545	27.9%	$29,984,421
Facility Inpatient	$32,284,120	$6,552,122	20.3%	$23,186,967
Facility Outpatient	$45,577,088	$5,147,832	11.3%	$32,646,937
Total In-Network	**$136,705,142**	**$27,661,151**	**20.2%**	**$88,040,644**
% of Allowed Charge	97.1%			
% Claim Frequency	91.7%			

Out of Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$622,880	$153,286	24.6%	$258,456
Non-Facility	$1,950,402	$636,741	32.6%	$472,762
Facility Inpatient	$613,213	$73,800	12.0%	$296,641
Facility Outpatient	$876,401	$125,731	14.3%	$344,781
Total Out of Network	**$4,062,896**	**$989,558**	**24.4%**	**$1,372,640**
% of Allowed Charge	2.9%			
% Claim Frequency	8.3%			

Secondary

Claim Type	Allowed Charge	Provider Discount		Paid
Ancilliary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Allowed Charge	0.0%			
% Claim Frequency	0.0%			

Allowed Charge = Provider Discount + Deductible + Copayment + Coinsurance + Paid Amount

Facility Inpatient = Any claim with a Room and Board Revenue Code (100-219)

Facility Outpatient = Any claim with Revenue Codes not Flagged as Inpatient

Non-Facility = Any claim with CPT Codes: 00100 - 99999

Ancillary = All other claims not flagged in Inpatient, Outpatient and Non-Facility

Plan Documentation Review

Plan Documentation Review Objective, Scope and Methodology

CTI evaluated the plan documents that governed the claims administration of the State's Cigna plans in 2013. CTI used these documents to develop a benefit matrix for the plans that maps each plan provision to the specific page of the Summary Plan Description. The benefit matrix served to inform our auditors and system analysts about the plans we were to audit.

Plan Documentation Review Findings

After CTI's review of the State's plan document and as observed through the course of the random sample audit (see CTI Audit Numbers referenced); it was noted that the State and Cigna agreed upon the following plan benefit clarifications. It was agreed that should any claim selected for audit reflect a correction made as a result of an opportunity Cigna had identified/clarified and corrected, no error would be assessed:

CTI recommends plan documents (Annual Change Booklets and Summary Plan Description) be updated accordingly to reflect the above, plus any other benefit clarifications identified by Cigna and/or the State.

Electronic Screening

Electronic Screening Objective and Scope

CTI performed electronic screening and analysis of 100 percent of each of the Medical service lines that comprise a Medical claim processed by Cigna during the 12 month period of January 1, 2013 – December 31, 2013 (the Audit Period). Cigna processed 331,817 claims (including adjustments) for 27,104 State of Montana claimants, representing 907,966 separate Medical service line items and resulting in $89,413,284 in payment by the plan. To perform this screening, we used our proprietary ESAS® software. The objective of our electronic screening and analysis is to identify and quantify claim administration system problems that appear to be causing payment errors.

Methodology for Electronic Screening

CTI used ESAS® to screen each Medical service line processed. ESAS® applies several hundred screening parameters to each line, to identify claims that may be paid in error. Any service line edited by ESAS® is considered "red-flagged," meaning it has the potential for having been over- or under- paid, based on the screening parameters set into ESAS® and the claim data provided by the claim administrator.

To validate electronic screening findings, CTI selects targeted samples from the "red-flagged" service lines identified by ESAS® to test. Our experience has shown that this type of sampling is necessary in order to validate that the claim data and the eligibility data provided was adequate to produce reliable screening results. CTI's auditors also followed up on screening results while they were onsite at Cigna's claim administration

facility. While CTI is confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the electronic screening results shown below represent potential, not actual, overpayments and process improvement opportunities. Additional testing of these claims by Cigna and State of Montana would be required to substantiate the findings and to provide the basis for remedial action planning.

Electronic Screening Audit Findings

No exceptions were noted as the result of targeted audit.

Random Sample Audit

Random Sample Audit Objective and Scope

The scope of our random sample audit included an onsite review at Cigna's claims processing facility in Bourbonnais, IL of a stratified random sample of 180 paid or denied claims for employees and dependents with coverage under the State of Montana Medical plans. The statistical confidence level of the audit sample was 95% with a 3% margin of error. Each claim in the sample was reviewed by a CTI auditor to ensure that it conformed to the plan specifications, agreements, and negotiated discounts. Additionally, the claims in the audit sample were used to verify that eligibility information is accurate and that claims are being paid only for eligible persons.

Random Sample Audit Methodology

Errors were cited when a claim selected in the random sample was paid or processed incorrectly, based on member eligibility or plan provisions defined in the Summary Plan Description or amendments to it. Payment errors were cited based on the documentation provided by the administrator for the sampled claim; errors remain even if they were later corrected, to allow for discussion between the employer and the administrator about how to reduce the error rate and the need to re-work claims.

Additional observations (not errors) were cited when processes or payments beyond the scope of the sample were observed. CTI's audit system categorizes errors into one or more of six Key Performance Indicators, defined in Exhibit C of this report. The performance results within each Key Performance Indicator are used by CTI to measure and benchmark claim administration performance against the performance of other claim administrators audited by CTI.

Written dialogue occurred between CTI and Cigna to arrive at a conclusion on any observation made by CTI's team during the onsite review. After all relevant discussion, CTI's auditors concluded if an error had occurred and if so, which type. In some cases, agreement was not reached and Cigna and CTI "agreed to disagree." All errors and the discussion between CTI and Cigna were recorded in CTI's audit system. A preliminary Random Sample Audit report was reviewed and responded to by Cigna and their written response was taken into consideration before producing this final report.

Random Sample Audit Findings

When compared with the performance of other plan administrators over the past 100 random sample audits conducted by CTI, Cigna's performance was above the median in five of the six Key Performance Indicators for which CTI has developed benchmarks to measure and monitor claim payment accuracy and administrative process. Claim Turnaround, the seventh Key Performance Indicator used by CTI to evaluate claim administration proficiency, does not have a benchmark. Same day turnaround on claims is the fastest turnaround time that can be achieved, but is not necessarily the best turnaround time. The claim administrator should balance claim turnaround by handling all types of claims as efficiently as possible. Cigna's median claim turnaround time of 11 calendar days requires improvement to maximize discount savings for State of Montana while keeping the number of resubmissions to a minimum. Cigna's administrative performance across all seven Key Performance Indicators is reflected in the following chart:

Key Performance Measures	Administrative Performance by Quartile			
	● Bottom Quartile	○ 2nd Quartile	○ 3rd Quartile	● Top Quartile
Documentation Accuracy -- Financial				●
Documentation Accuracy -- Frequency				●
Financial Accuracy	●			
Accurate Payment Frequency			○	
Adjudication Proficiency			○	
Accurate Processing Frequency				●
Claim Turnaround Time (From Date Received to Date Processed)	**Median Turnaround Time Requires Improvement at 11 days.**			

For more specific information on how Cigna's performance in this audit compared to other audits performed by CTI, see the "Box and Whiskers" charts in Exhibit A. Additionally, the charts in Exhibit C. provide statistical process control tools and information to determine materiality, underlying causes, and corrective actions for the problems and improvement opportunities identified through the random sample audit.

Financial Accuracy of 96.91%, when imputed to the universe of approximately $89.4 million in paid claims during the one-year random sample audit period, indicates Cigna made errors totaling approximately $2.76 million during the random sample audit period. Of the financial errors cited in our random sample of Medical claims, 87% of the financial errors were overpayments, while 13% were underpayments. While overpayments represent opportunity for initiating recovery and saving money for the State plan, underpayments also are of concern. Each underpaid claim is likely to result in an appeal from a provider or a State of Montana employee with a corresponding claims adjustment that may increase administrative costs as a result of "double-handling" claims. Three of the four payment errors we cited related to Cigna's improper application of Coordination of Benefits provisions. The types and frequency of financial errors cited during the random sample audit are indicated on the following page:

Error Category	Number of Errors Cited
Incorrect COB with Medicare Errors	2
Incorrect COB Error	1
Frequency Limits Error	1
Total Number of Financial Errors in 180 Claim Sample	**4**

Summary of Recommendations from the Comprehensive Audit

Based on the findings of our comprehensive claim administration audit of Cigna, we recommend the following next steps:

1. Discuss with Cigna an approach to conducting further focused analysis of the errors identified through the random sample audit relating to coordination of benefits to achieve correct processing upon initial review, rather than through adjustments required post-payment to correct errors.
2. Discuss whether use of the CMS Correct Coding initiative edits would result in further cost savings for the State.
3. Amend the Administrative Service Agreement to require a higher level of required performance (at least 99%) for claim accuracy.
4. Continue to conduct sequential audits to ensure performance guarantees are met.

We understand that the State will review these recommendations to determine the subject of immediate action. Where the State determines that our assistance would be beneficial in implementing or performing any of the required tasks, we will be pleased to provide cost estimates for these services on an hourly or fixed-fee project basis. Included in our Comprehensive audit specifications are 10 hours for post-audit follow-up activities on issues identified by the audit.

We have considered it a privilege to have worked for and with the State's staff in these important endeavors and would welcome any opportunity to assist you in achieving your future objectives. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

Exhibits

A. Performance Measurements and Benchmarking

B. Prioritization of Errors and Savings Opportunities

C. Key Performance Indicators Operational Definitions

Exhibit A.

Performance Measurement and Benchmarking

Based on the 100 most recent claim administration audits CTI has performed, the following "Box and Whiskers Charts" show Cigna's claim administration performance for each Key Performance Indicator as compared to that for other plans audited by CTI. Each chart contains the following information:

- Cigna's Performance
- Benchmark Performance
- Lowest Performance
- Performance levels in quartiles with the 4th Quartile representing the performance of the 25 plans with the best performance and the 1st Quartile representing the 25 plans with the lowest performance
- Performance relative to the Median level or the reported level at which 50 of the plans audited by CTI were reported to be better and 50 were reported to be worse

Chart 1. – Financial Accuracy

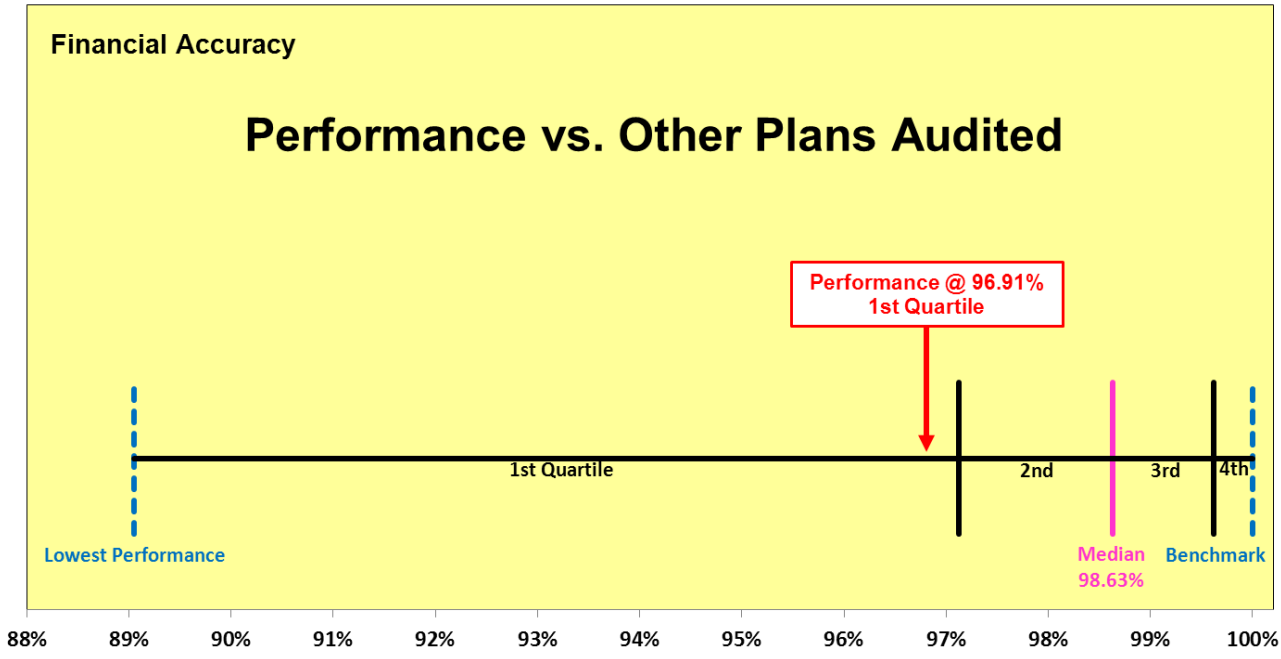


Chart 2. – Accurate Payment Frequency

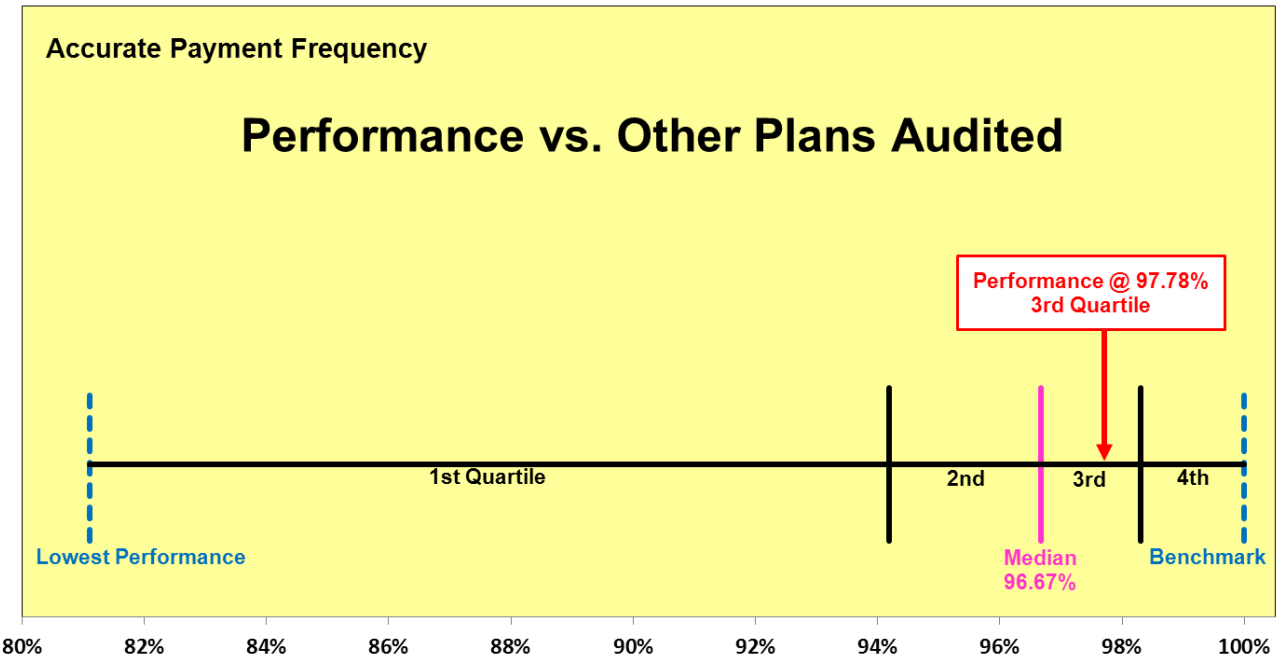


Chart 3. – Adjudication Proficiency

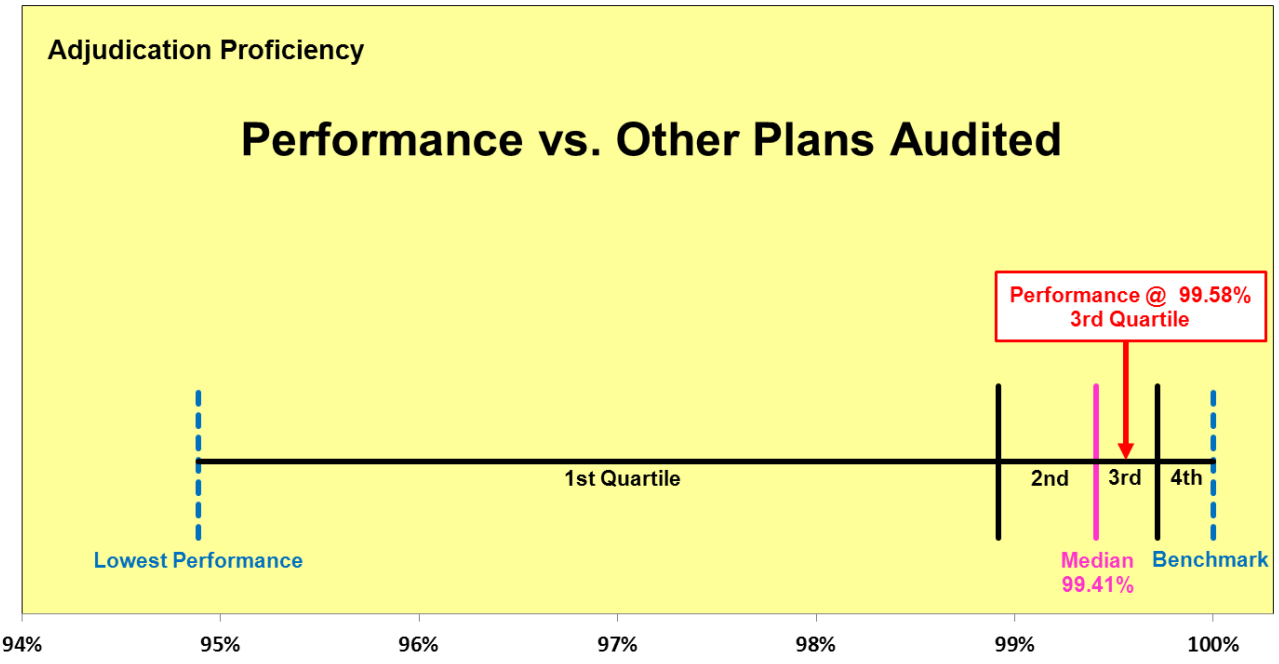


Chart 4. – Accurate Processing Frequency

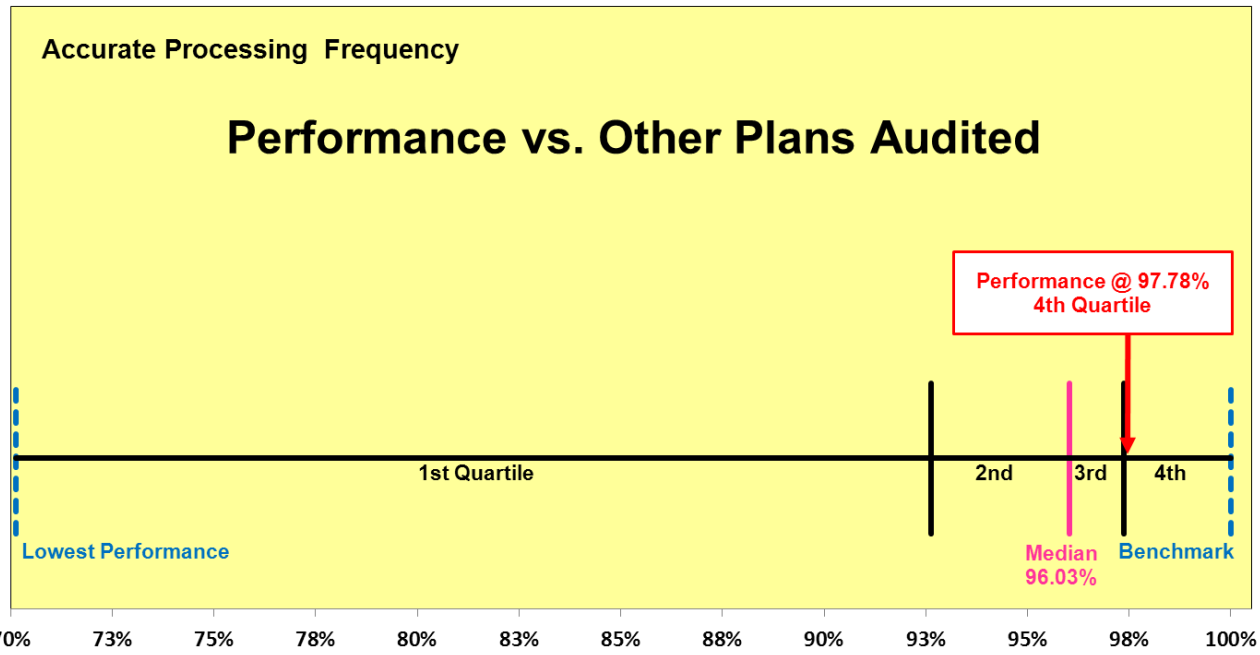


Chart 5. – Documentation Accuracy Financial

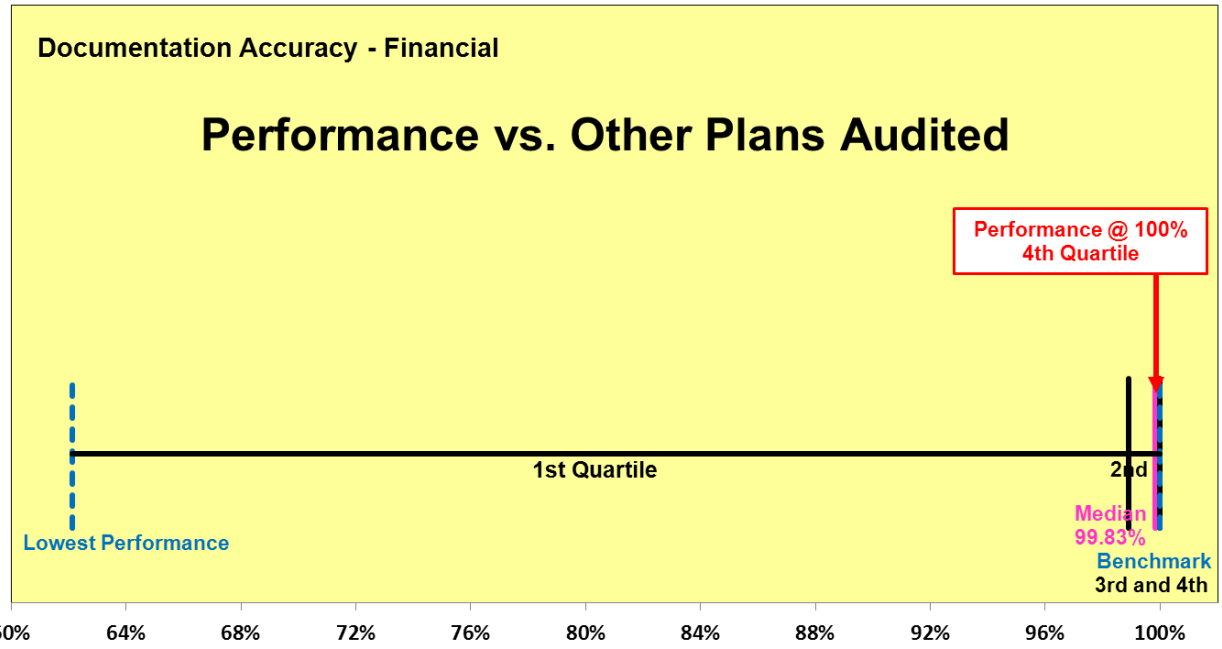


Chart 6. Documentation Accuracy Frequency

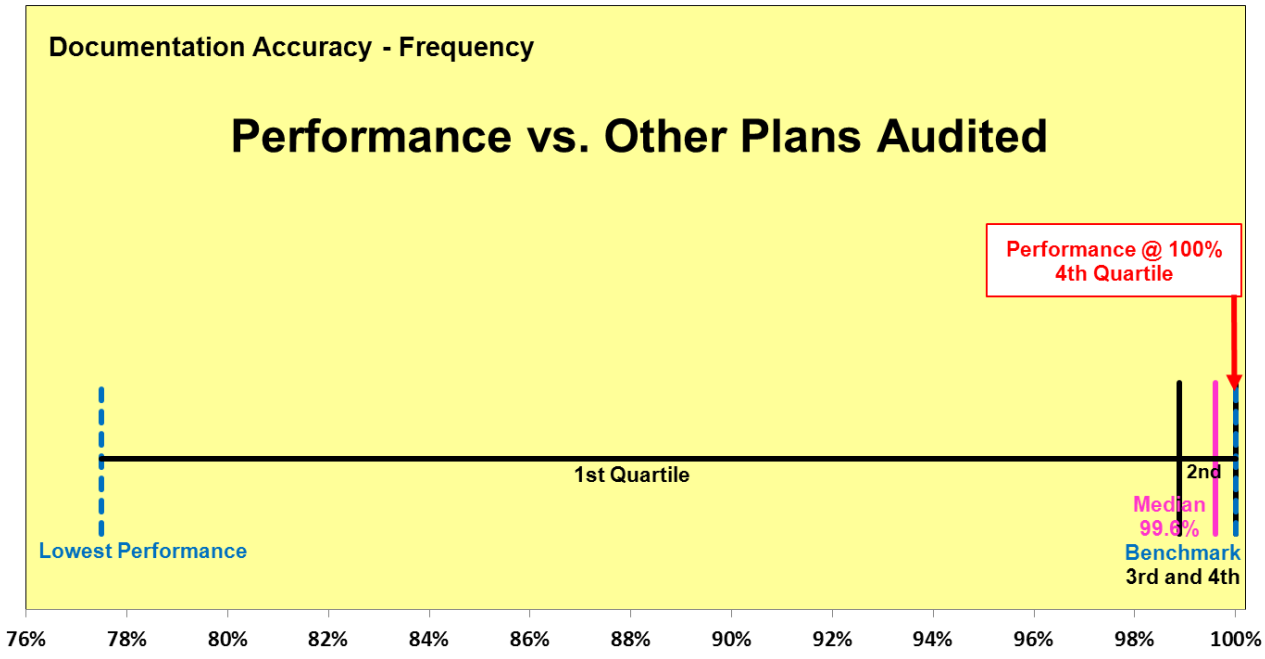


Chart 7. Claim Turnaround

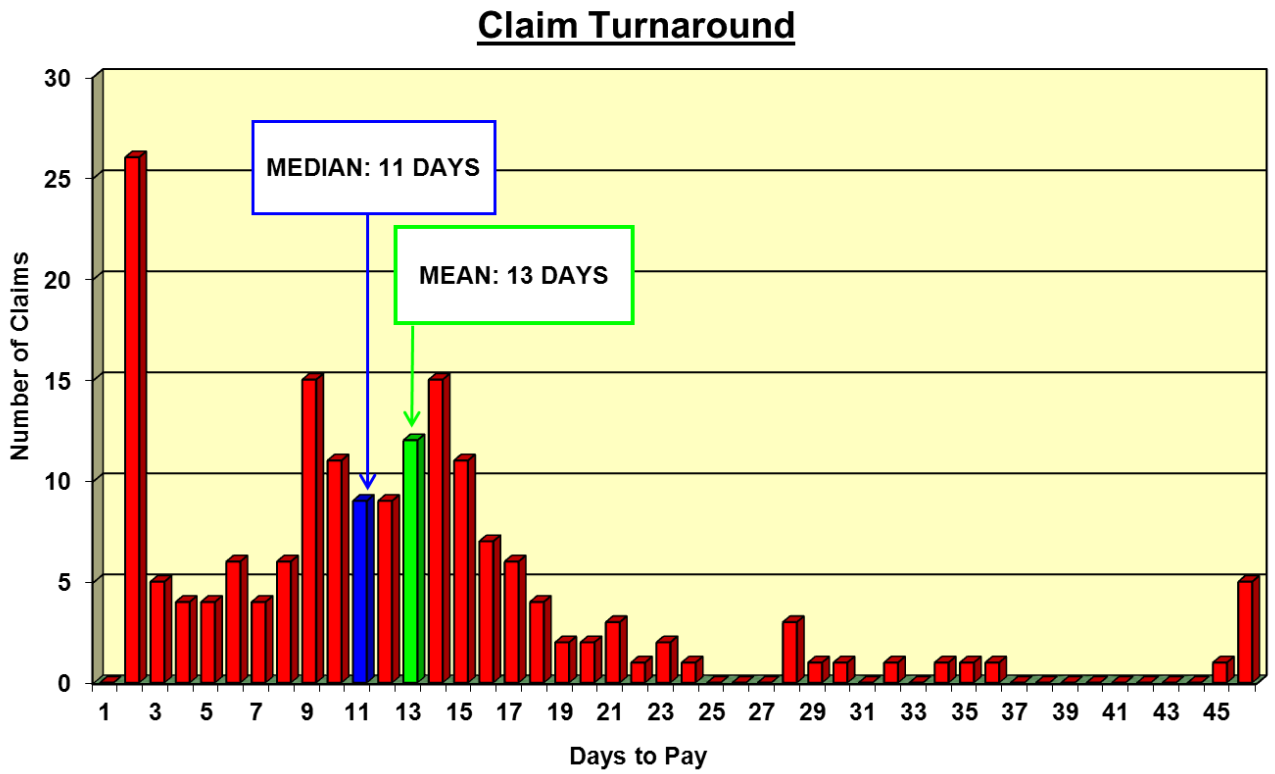


Exhibit B.

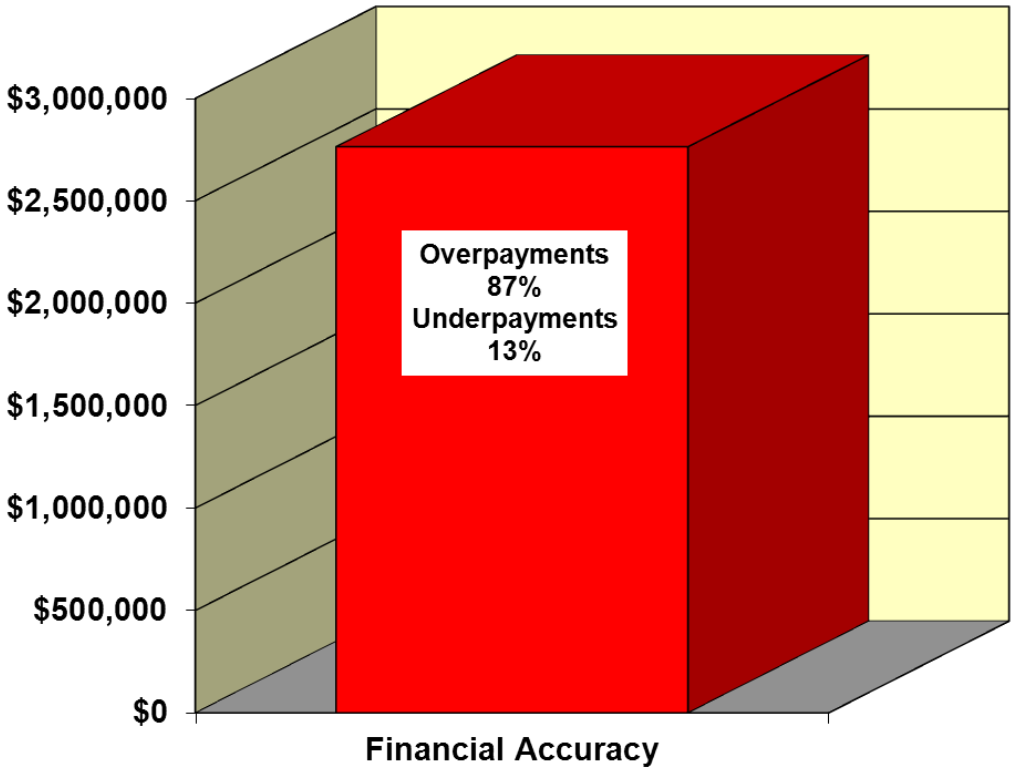
Prioritization of Process Improvement Opportunities

Derived from the Random Sample Audit data, the following charts provide statistically based insights to assist in prioritizing improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes.

The following Pareto chart ranks in order of materiality the potential annual financial impact achievable by improving key process performance from the level demonstrated in the audit to the benchmark.

Chart 1.

Potential Cigna Improvement – Financial
$89,413,284 Annual Paid Medical Claims for State of Montana



The following pie charts (Charts 2-5) show the frequency of errors made by Cigna by type of error so that remedial actions can be taken to prevent their recurrence in the future.

Chart 2.

Cigna Overall Processing Accuracy
Based on Random Sample

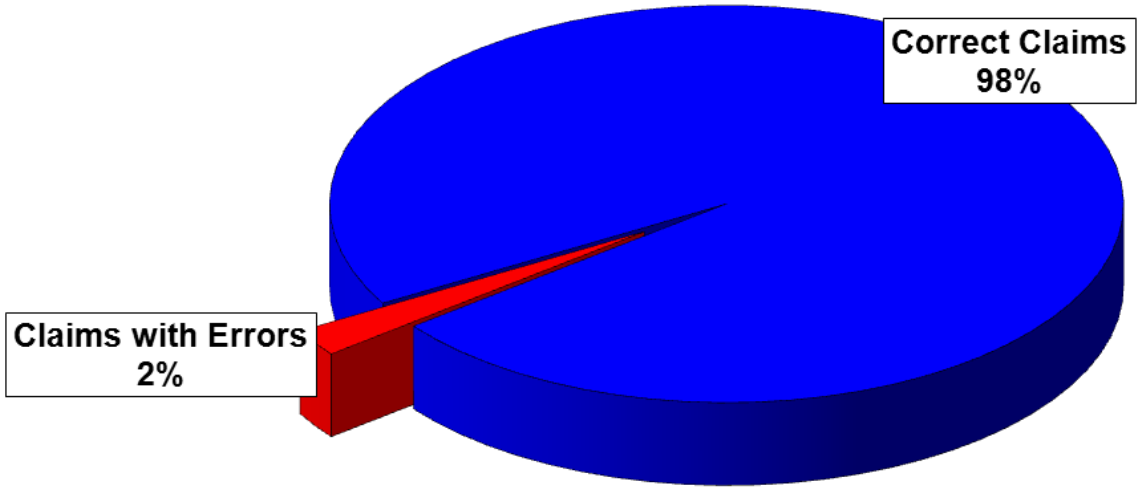


Chart 3.

Cigna Frequency of Financial Errors by Type
Based on Random Sample

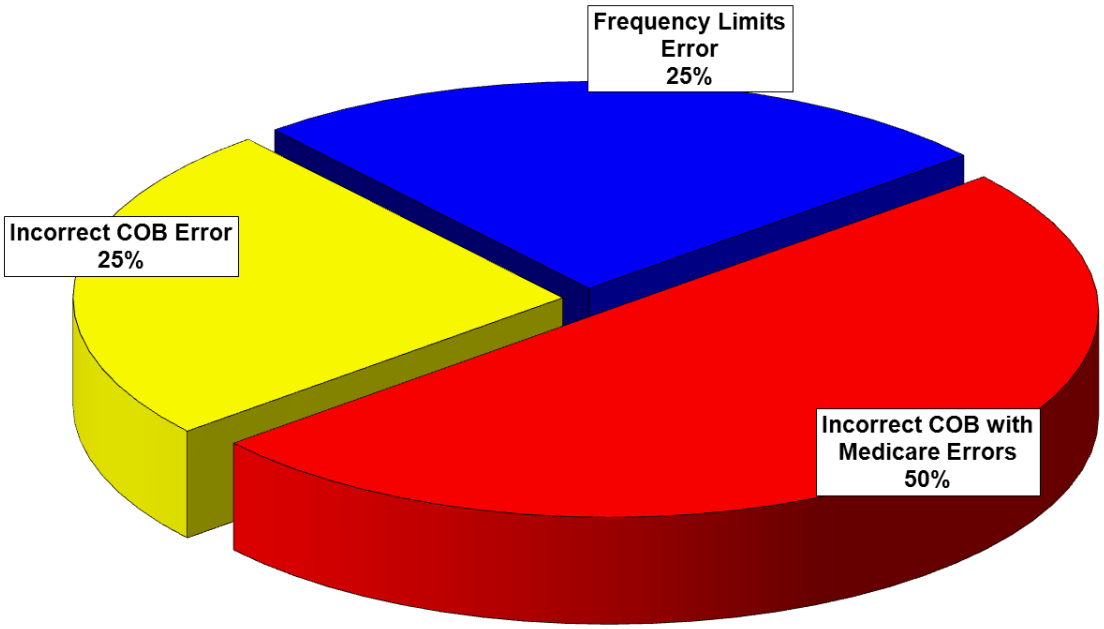


Chart 4.

Cigna Frequency of Adjudication Errors By Type
Based on Random Sample

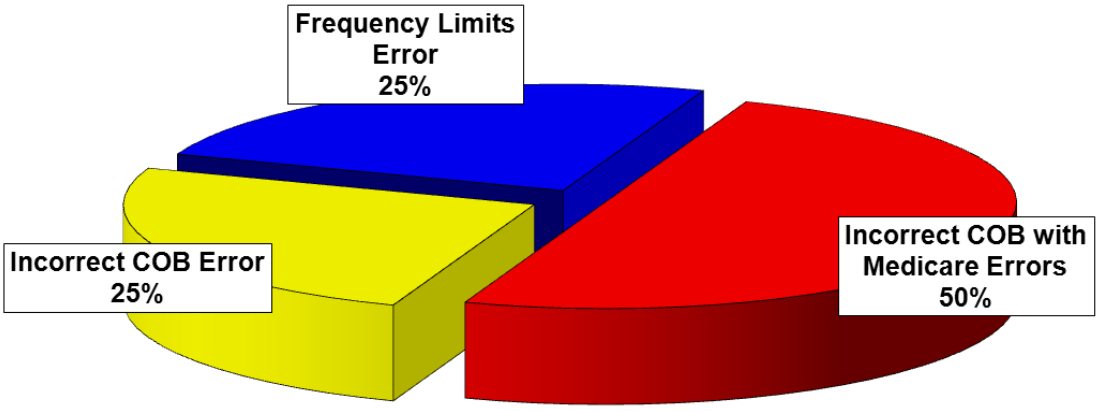


Chart 5.

Cigna Frequency of Policy Provision Errors By Type
Based on Random Sample

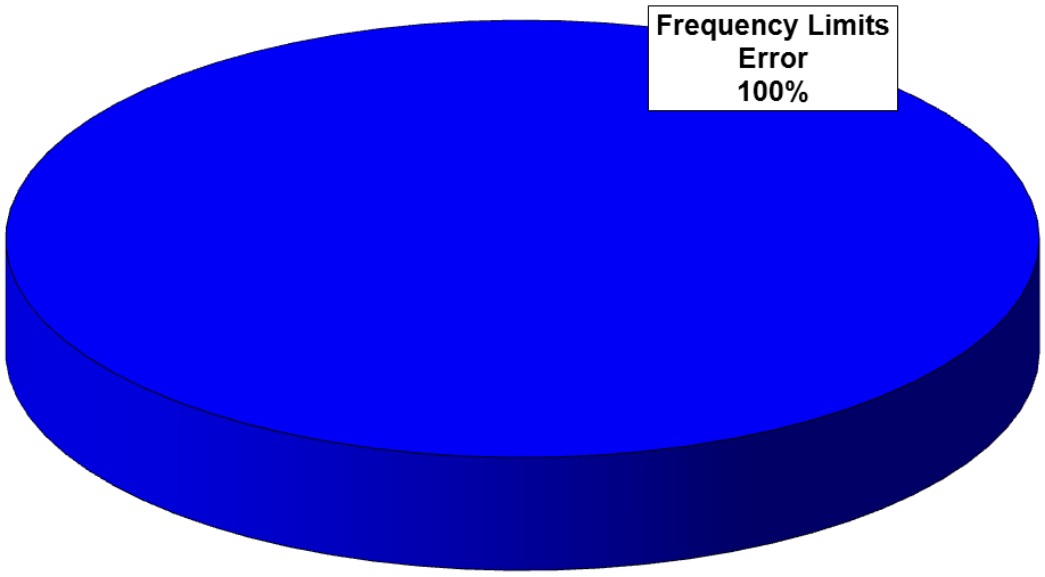


Exhibit C.

Key Performance Indicators and Operational Definitions

CTI Key Performance Indicators for Payment Accuracy and Proficiency

Financial Accuracy - compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency - compares the number of bills paid correctly to the total number of bills paid.
Documentation Accuracy Financial - compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Claim Turnaround - is the number of calendar days required to pay a claim -- from the date the claim is received by the administrator to the date a payment or denial is mailed.

CTI Key Performance Indicators for Procedural Accuracy and Proficiency*

Adjudication Proficiency - compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Documentation Accuracy Frequency - compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.
Accurate Processing Frequency - compares the number of bills processed without errors of any type (financial or non-financial) to the total number of bills processed.

** These measures may or may not have caused payment errors, but will be indicators of the type and frequency of procedural deficiencies that could result in payment errors.*

COMPREHENSIVE CLAIMS ADMINISTRATION AUDIT

SPECIFIC FINDINGS REPORT

The State of Montana Medical Plan
Administered by:
Cigna
Audit Period: January 1, 2013 – December 31, 2013

Presented to:

The State of Montana

April 28, 2014

Presented by:
Claim Technologies Incorporated

Preface

The Specific Findings Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) comprehensive audit of Cigna's claims administration of the State self insured medical plans. The statistics, observations, and findings herein constitute the basis for the analysis and recommendations presented separately in the accompanying Executive Summary.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Cigna, and CTI in their efforts to serve the interests of the plan participants of the State medical Plans. This report is based on data and information provided to CTI by the State and Cigna. CTI's compilations and findings rely upon the accuracy and completeness of that information and the samplings taken from it.

CTI is a firm specializing in audit and control of health plan claims administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of Cigna's claims process and systems and to the accuracy and validity of the State's paid claims during the audit period.

We conducted our audit in accordance with standards and procedures generally accepted and in common practice for medical plan claims audits in the insurance industry of the United States.

CLAIM TECHNOLOGIES INCORPORATED
April 2014

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Introduction

CTI performed a comprehensive audit of Cigna's claims administration of the State medical plans for the 12 month period of January 1, 2013 through December 31, 2013. We conducted our audit in accordance with standards and procedures generally accepted and in common practice for medical plan claims audits in the insurance industry of the United States. We planned and performed our audit to obtain reasonable assurances that claims were adjudicated according to the plan benefits; and to form our opinion as to the overall efficacy of Cigna's financial controls, accuracy and validation of paid claims. The audit included the following components:

CTI Comprehensive Audit

I. Operational Review	**Pre-Audit Questionnaire with In-Field Examination and Testing** • Claims Administrator Information • Claims Administrator Claim Fund Account • Administrator Claim Adjudication • Administrator Eligibility Maintenance Procedures • HIPAA Compliance
II. Plan Documentation Review	**Evaluation of Plan Documentation** • Gray Area Clarification
III. Electronic Screening [screening encompassed 100% of Paid Claims during the audit period]	**Problem Identification and Substantive Testing in Proven Control Risk Categories** • Verification of Eligibility • Identification of Savings Opportunity and Potential Overpayments • Immediate Remedy of Costly Leaks and System Problems
IV. Random Sample Audit [Sample Confidence @ 95% +/- 3%]	**Measurement and Comparison of Administrator Performance** • Performance Metrics for Key Indicators • Benchmarking vs. Best-in-Practice • Problem Identification and Prioritization • Error Identification by Type and Frequency • Statistically-Based Remedial Action Plans • Systematic Monitoring and Control

Audit Process Overview

CTI's Comprehensive Audit is designed to measure and facilitate continuous quality improvement of the processes of claims administration. We audit claims administration performance both electronically through screening and analysis of 100% of the claims data, and statistically through an audit of a stratified random sample of claims processed during the audit period specified. Statistics regarding the population of claims and amount paid by the Plan during the 12 month audit period are shown below:

Total Paid Amount	$89,413,284
Total Number of Claims Paid/Denied	331,817

Below is an overview of the systems used and protocols followed in completing this comprehensive audit.

Audit Planning and Protocol

Audit Process and Procedures Reviewed and Agreed Upon: CTI's audit process and timeline are reviewed in advance with the Plan Sponsor who commissioned the audit and then with the Claim Administrator who will be audited. The Administrator is informed that although agreement may not always be reached on the findings reported, it is CTI's policy always to present the Administrator's views in addition to its own.

Pre-Audit Preparation

- **Operational Review:** CTI's Operational Review process utilizes a detailed four-part Operational Review Questionnaire that is sent to and completed by the Claim Administrator. The Administrator's responses and supporting documentation are used to evaluate systems, staffing, and procedures related to claims administration including enrollment and overpayment recovery. CTI verifies the responses of the Administrator on key operational processes by utilizing its electronic screening system to identify a small number of candidate cases that are exemplary of that process to test while we are in the field. CTI also uses the questionnaire responses to prepare for its Random Sample Audit and Electronic Screening.
- **Plan Documentation Review:** Preparation for the Comprehensive Audit includes CTI's in-depth evaluation of all relevant plan documentation including the Member Handbook and amendments, the Administrative Service Agreement. The provisions of these documents constitute the specifications against which claim payment accuracy and process quality are audited.
- **Random Sample Selection:** Using proprietary methods and software, CTI constructs a stratified random sample, which supports a 95% confidence level with a bound of +/- 3.0%.

- **Initial Electronic Screening:** CTI's proprietary screening software, ESAS®, produces reports of claims "Red Flagged" by Control Risk Category. Control Risk Categories are categories of claims that have been proven through experience to have a higher risk of payment error in that they may require more complex adjudication processes.

Targeted Sampling

Targeted samples are selected from the most material categories of ESAS®. CTI prepares and sends questionnaires called Substantive Testing Questionnaires for each sampled item to the Claim Administrator. The final ESAS® screening results are presented to the Plan Sponsor in the Electronic Screening section of this report. These results are intended for use in determining if any category has sufficient materiality or control risk to warrant further focused review or discussion on recovery/savings potential.

Random Sample Audit

Each claim selected in the Random Sample Audit is reviewed by a CTI auditor with respect to the Plan Document, agreements and contracts that govern the way that claim should be processed. Each error observed and any Additional Observation made is recorded and the Administrator is given ample opportunity to rebut the error. The results of the Random Sample Audit are presented in the Random Sample Audit section of this report.

Review of Audit Draft Reports

Preliminary Working Drafts of the Electronic Screening and Random Sample Audit sections of this report are sent to the Claim Administrator to allow a final opportunity for rebuttal of errors. The Administrator's responses to the Preliminary Working Drafts are taken into consideration before completion of the final reports and are included in the Exhibits of those report sections.

Analysis, Quantification, and Recommendations

The information and details resulting from the systems and protocols described previously are presented in this Specific Findings Report. Separately in the Executive Summary the results are summarized and represented using statistical analysis and continuous quality improvement tools developed by CTI for this purpose. Through this analysis, improvement opportunities are prioritized and recovery and remedial action recommendations are made for the consideration of the plan sponsor and the Claim Administrator. The Executive Summary is provided to the plan sponsor upon completion of the audit, but we do not provide a copy to the Claim Administrator unless so instructed.

PLAN DOCUMENTATION REVIEW

The State of Montana Medical Plan
Administered by:
Cigna
Audit Period: January 1, 2013 – December 31, 2013

Prepared: April 25, 2014

PLAN DOCUMENTATION REVIEW

Table of Contents

Overview

Plan Documentation Review Objectives

The objectives of the Plan Documentation Review are to evaluate the plan documentation that governs the administration of the State of Montana (the State) self-insured medical plan and to create knowledge on the part of our auditors about the plan that they will be auditing through the electronic screening and random sample audit phases of this comprehensive audit. The Plan Documentation Review results in the development of a Benefit Matrix for each plan to be audited. The matrix is used by CTI's auditors in the Comprehensive Audit process.

Plan Documentation Review Scope

CTI auditors evaluate the following documentation that is in force during the audit period for the plan(s) that we are to audit:

- Plan Documents/ Summary Plan Descriptions and all amendments,
- Administrative Services Agreement.

Plan Documentation Review Methodology

CTI obtains a copy of the plan documentation from both the claim administrator and the plan sponsor. We compare the documents from the two sources to ensure that they match in every way.

Using a tool that we have developed for this purpose called the "Benefit Matrix", CTI performs and documents the results of an in-depth review of the Plan Documents/ Summary Plan descriptions and amendments, noting any inconsistencies and missing provisions. The Benefit Matrix includes all plan provisions most frequently encountered in CTI's audits of medical plans. CTI creates a Benefit Matrix for each plan being audited.

CTI obtains clarification from the plan sponsor to any inconsistencies and missing provisions in the Plan Documents/ Summary Plan descriptions and amendments observed through the process of completing the Benefit Matrix. We refer to the items requiring clarification as "Gray Areas". The plan sponsor's clarification is incorporated into the Benefit Matrix and is tested as are all other provisions of the plan(s) through the Electronic Screening and Analysis and Field Audit.

The provisions of the plan documentation constitute the specifications against which claim payment accuracy and process quality are audited by CTI.

The following section describes CTI's observations regarding the plan documentation. Gray area clarifications that CTI requested as a part of this audit are shown in Appendix A.

Plan Documentation Review Findings

After CTI's review of the State's plan document and as observed through the course of the random sample audit (see CTI Audit Numbers referenced); it was noted that the State and Cigna agreed upon the following plan benefit clarifications; and it was agreed that should any claim selected for audit reflect a correction made as a result of an opportunity Cigna had identified/clarified and corrected, no error would be assessed:

- Cigna updated their claim system to apply a $100 copay to ER Physician for the Choice Plan and $250 for ER facility claims, waiving deductible per clarification from the State. (see CTI Audit # 1114)

- The Allergy and Injections benefit in an office setting was updated to process at coinsurance, plan deductible waived. (see CTI Audit #s 1028 and 1063)

- Urgent care benefit was updated to pay physician line only at $35 copay and 100%, all other services subject to deductible and coinsurance. (this scenario was not observed in the random sample)

- Claims from Sleep Diagnostics were to be processed and allowed without requirement for authorization (gold card status). (see CTI Audit # 1150)

- Benefits for the first colonoscopy, regardless of diagnosis (preventive or diagnostic), is to be covered at 100%, all subsequent services paid at place of service bounds. (see CTI Audit #s 1040 and 1085)

- An accumulator rebuild for the Classic Plan due to identifying cross-accumulation not in place. This created adjustments for claims over maximum. (see CTI Audit # 1137)

- A process was created to allow claims billed with a T-code to process against Autism benefit (per State mandate). (this scenario was not observed in the random sample)

Plan Documentation Review Recommendations

CTI recommends plan documents (Annual Change Booklets and Summary Plan Description) be updated accordingly to reflect the above, plus any other benefit clarifications identified by Cigna and/or the State.

Exhibit

A. Gray Area Clarification

Exhibit A.

Gray Area Questions

1. Is there any Deductible Carry-over from one Benefit Year to another? The SPD and Enrollment Booklets are silent. No, the State of Montana deductibles start over every calendar year.

2. Is Cognitive Therapy covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. The State of Montana follows the TPA medical policy regarding cognitive therapy.

3. Is Genetic Counseling covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. No, benefits are not available. We do follow TPA medical policy regarding genetic testing. "Services or procedures that are: not medically necessary to treat active illness or injury, or specifically listed as a benefit;" also "Services and supplies not provided by a covered provider or which are not listed as a benefit of state indemnity medical plans in this Summary Plan Description".

4. Are Automated Labs covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. Not familiar with this term.

5. Is Pre-admission Testing covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. If it is medically necessary. For example, if a patient needs an EKG prior to surgery because of a heart issue, benefits are available.

6. Is Recreation Therapy covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. No, benefits are not available. Refer to Exclusions and Limitations "Services or procedures that are: not medically necessary to treat active illness or injury, or specifically listed as a benefit;" also "Services and supplies not provided by a covered provider or which are not listed as a benefit of state indemnity medical plans in this Summary Plan Description".

7. Is Respite Care covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. No, benefits are not available. Refer to Exclusions and Limitations "Services or procedures that are: not medically necessary to treat active illness or injury, or specifically listed as a benefit;" also "Services and supplies not provided by a covered provider or which are not listed as a benefit of state indemnity medical plans in this Summary Plan Description".

8. Is a Second Surgical Opinion covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent. Yes, we treat this like any other medical visit.

9. Is Smoking Cessation covered? If so, at what benefit level? The SPD and Enrollment Booklets are silent.
   Not covered per SPD under Exclusions and limitations "Services or procedures that are: not medically necessary to treat active illness or injury, or specifically listed as a benefit;" also "Services and supplies not provided by a covered provider or which are not listed as a benefit of state indemnity medical plans in this Summary Plan Description". Starting in 2010 we did start to offer a tobacco cessation benefit under our Wellness program. Refer to Annual Change booklet under Wellness Programs. With an authorization from the State, medical claims could process. Auth has to be in place.

OPERATIONAL REVIEW REPORT

State of Montana

Administered by:
Cigna

Audit Period: January 1, 2013 – December 31, 2013

Prepared: April 28, 2014

OPERATIONAL REVIEW REPORT

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Overview

Operational Review Objectives

The objectives of the Operational Review are to evaluate Cigna's systems, staffing, and procedures related to claims administration, including enrollment and overpayment recovery, of the State of Montana (State) medical plans. The Operational Review also is used in support of our random sample audit and electronic screening activities.

Operational Review Scope

The scope of our Operational Review is to evaluate the systems, staffing and procedures related to claims administration including eligibility maintenance, enrollment, customer service, appeals processing and fraud, waste and abuse control. Specifically we reviewed these aspects of Cigna's administration to observe any deficiencies that might materially affect Cigna's ability to control risk and pay claims on behalf of State. Information and supporting documentation or reports are gathered through the use of an Operational Review Questionnaire. The operational functions verified and/or assessed through the Questionnaire include:

- Claims Administrator Information
  - Insurance and bonding of the Claim Administrator
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claims payment system and coding protocols
  - Security of data and systems
  - Staffing
- Administrator's Claim Fund Account
  - Claim funding mechanism
  - Check processing and security
  - COBRA/ Direct Pay Premium Collections
- Administrator's Claim Adjudication Customer Service and Eligibility Maintenance Procedures
  - Exception claims adjudication procedures
  - Eligibility maintenance and investigation procedures
  - Overpayment recovery
  - Customer Service Call and Inquiry Handling
  - Network utilization
  - Utilization review, case management and disease management
  - Appeals processing
- HIPAA Compliance
- Preferred Provider Utilization and Savings

CTI utilizes its proprietary Electronic Screening and Analysis (ESAS®) software to identify candidate cases to test the operational processes related to claim adjudication and eligibility maintenance.

Operational Review Methodology

CTI typically gathers information from claim administrators like Cigna through the use of a four-part "Operational Review Questionnaire". The questionnaire is modeled after the audit tool used by CPA firms when they conduct an SSAE-16 audit of a service administrator. CTI modified the questionnaire to request more information than the SSAE-16 typically requires, but also to attain information specific to Cigna's administration of State plans, rather than its overall book of business.

CTI's audit staff reviewed the responses and the supporting documentation and reports and prepared follow-up questions to be completed by Cigna and during the on-site visit.

Cigna's claim adjudication and eligibility maintenance procedures as described in its responses to that section of the Operational Review Questionnaire were tested through a focused audit of a sample of candidate cases identified by CTI's proprietary ESAS® software. A CTI auditor set up parameters in ESAS® specific to the procedures described in Cigna's questionnaire responses. The focused audit was conducted using a survey tool called a "Substantive Testing Questionnaire" that was sent to Cigna for completion on each selected case. Responses from Cigna were used to validate that the administrative procedures described in their response to the Operational Review Questionnaire were being followed during the audit period. A complete list of the ESAS® Screening Categories and Subcategories used to identify candidate cases for Operational Review Testing is shown in Figure 1.

Figure 1.

ESAS® Screening Categories for Operational Review Testing			
ESAS® Screening Category and Subsets	**Evaluate Procedure**	**Quantify Errors**	**Reason Codes**
Duplicate Payments to Providers and/or Employees			
Duplicates within same claim	☑		DP1C
Fraud, Waste and Abuse			
Large Payments Direct to Employees	☑		LGEE
Unnecessary Nerve Conduction Studies	☑		NCST
Invalid Procedure Codes	☑		ULPC
Gender Specific	☑		GENx
Subrogation/Right of Recovery from Third Party			
Accidents and Injuries	☑		SBxx
Workers' Compensation			
Potential Workers' Compensation	☑		WCxx

Coordination of Benefits			
Paid Primary Should be Secondary to Other Group Insurance	☑		CB01
Active Employee, Over 65; Plan should be Primary to Medicare	☑		MCAS
Retired Employee, Plan should be Secondary to Medicare	☑		MCRP
Denial of Mandated Benefits			
Should not have denied - Suicide	☑	☑	DE01
Should not Deny Reconstructive Surgery after Cancer (WHCRA)	☑	☑	DE02
Specific Reinsurance Reimbursements			
Specific Reinsurance Attachments	☑	☑	REIN
Large Claim Review			
Claimants over $100,000	☑		CMLG
Case Management			
Diagnosis Specific	☑		CMXX
Hemophilia/Blood Products	☑		HEMO
Provider Discounts and Fees			
In-Network Discounts vs. Usual Reasonable and Customary (URC)	☑	☑	UIxx
Non-Network (Secondary Discounts) vs. URC	☑	☑	USxx
Non-Network (no discounts) vs. URC	☑	☑	UOxx
PPO Provider but No Discount Taken	☑	☑	PDSC
Non-PPO Provider with Incorrect Copayment	☑	☑	PPCO
Dependent Child Eligibility			
Payments for Ineligible Grandchildren	☑	☑	GCxx
Payments for Over Age Dependents	☑	☑	OVxx

Findings by Screening Category

This section of the report includes the ESAS® Summary report showing by category the number of line items or claims and the total potential amount at risk that remain now at the conclusion of our analysis and substantive testing protocols.

Following the ESAS® Summary report is a detailed explanation of our Substantive Testing results, findings and recommendations if it is our opinion that process improvement or recovery/ savings opportunities exist.

Note: If CTI is making an improvement recommendation, it will be denoted by a “Yes” in the final column of the ESAS® Summary reports.

The results of the screening in these categories are shown in Figure 2. *Copies of the ESAS® questionnaires for Operational Review are included with the Specific Findings for Electronic Screening and Analysis.*

Figure 2.

ESAS - Summary (as of 04/22/2014)

Categories for Operational Review

Client: Montana State - CIGNA
Screening Period: 01/01/2013 - 12/31/2013

Analysis Final Results

Claims Red Flagged	62,478
Claimants Red Flagged	15,384
Paid Amount Red Flagged	$34,407,423
Potential Amount at Risk:	$2,772,057

Category	Lines	Clmts	Description	Charge	Paid	Potential	At Risk	Improvement
Duplicate Payments to Providers and/or Employees								
DP1C	268	94	Duplicate Payments to Providers and/or Employees	$24,572	$41,782 *	$17,210 *		
Fraud, Waste, and Abuse								
NCST	28	23	Unnecessary Nerve Conduction Studies	$9,567	$3,899			
ULPC	360	223	Invalid Procedure Codes	$150,257	$179,593			
GENx	3	3	Gender Specific	$839	$367			
Subrogation/Right of Recovery from Third Party								
SBxx	40343	5006	Subrogation/Right of Recovery from Third Party	$10,676,775	$5,004,532			
Workers' Compensation								
WCxx	4316	631	Workers Compensation	$1,564,041	$806,930			
Coordination of Benefits								
CB01	20	3	Paid Primary Should be Secondary to Other Group Insurance	$547	$8			
Denial of Mandated Benefits								
DE01	3	1	Denied, Possible Self-Inflicted Injury	$17,891	$0		($17,891)	
DE02	7	3	Denied, Reconstruction	$17,343	$0		($17,343)	Yes**
Large Claim Review								
CMLG	51076	112	Claimants over $100,000	$29,605,334	$20,915,130			
Case Management								
CMxx	12045	1243	Case Management	$3,420,071	$1,468,128			
HEMO	30	2	Hemophilia/Blood Products	$116,295	$108,758			
Provider Discounts and Fees								
UI80	9073	4358	In-Network UCR at 80th, at 5.00 tolerance	$6,211,089	$3,871,415		$2,267,415	
UO80	11	7	Out-of-Network UCR at 80th, at 5.00 tolerance	$1,268	$871		$341	
PDSC	76569	10762	PPO Provider and No Discount Taken	$5,964,833	$5,895,200			
PPCO	2320	376	Non-PPO Provider with Incorrect Copayment	$199,902	$95,672			
Dependent Child Eligibility								
OVxx	1824	89	Payments for Over Age Dependents	$738,132	$522,325		$522,325	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

**** Please refer to Exhibit A in Part 4 - Substantive Testing Questionnaire Responses and CTI Conclusions for additional detail on the categories of Duplicates and Denied Reconstruction findings.**

Correct Coding Initiatives

OBJECTIVES: The Centers for Medicare & Medicaid Services (CMS) mandates several initiatives that prevent improper payments of Medicare Part B and Medicaid claims. The overall goal of the initiatives is to reduce payment errors by identifying and addressing billing errors made by providers.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines to have potentially been incorrectly coded according to the guidelines provided by CMS.

Substantive Testing

Substantive Testing Questionnaire (QID) numbers 29-30 were sent to Cigna. Cigna responded to all the questionnaires submitted. Copies of the responses are provided in Exhibit A.

The results of the Substantive Testing are shown in the following report entitled “Correct Coding Initiative”.

Correct Coding Initiatives

The Centers for Medicare & Medicaid Services (CMS) mandates several initiatives that prevent improper payments of Medicare Part B and Medicaid claims. The overall goal of the initiatives is to reduce payment errors by identifying and addressing billing errors made by providers. While these edits are not mandatory for employer sponsored medical plans, it is important that employers understand the benefits of these initiatives and their potential value when applied to non-Medicare/Medicaid medical plans.

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B and Medicaid claims. The coding policies are based on the following:

- Coding conventions defined by the American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- National and local Medicare policies and edits
- Coding guidelines developed by national societies
- Standard medical and surgical practice

NCCI edits are provided, free of charge, by CMS and are updated on a quarterly basis. The AMA supports the standardization of these code-edit systems and advocates the coordination of effort among all medical claim payers.

CMS implemented five separate Claim Review programs to help control the cost of the Medicare and Medicaid programs. The two CMS initiatives that can provide the greatest benefit to employee benefit plan managers of self-funded plans are the:

- Procedure-to-Procedure Edits, and
- Medically Unlikely Edits (MUEs).

CTI has retrospectively identified potential overpayments for the medical plans being audited as if the CMS guidelines had been utilized. These reports also can be used to help employers evaluate the strength of their administrator's prepayment claim review methodologies.

Procedure-to-Procedure Edits

The Procedure-to-Procedure Edits compare procedure codes from multiple claim lines on the same day. These CMS edits dictate when procedures from multiple lines of a claim cannot be billed together. There are numerous edit algorithms required, as well as many exceptions when code modifiers are used; all good reasons to verify that these CMS edits are being properly implemented and maintained by your administrator. If your administrator is not currently using these CMS edits, CTI's audit reports will help you evaluate the savings potential as if the **Procedure-to-Procedure Edits** had been in place.

The Procedure-to-Procedure Edits are split by CMS into two parts:

- Outpatient Hospital Services, and
- Non-Facility Claims (CPT codes 00100-99999)

Following are CTI's NCCI Procedure-to-Procedure Edit Reports for procedure code combinations with greater than $3,000 in potential overpayments:

Procedure to Procedure Edits

greater than $3,000 paid
Based on Paid Dates 01/01/2013 thru 12/31/2013

Outpatient Hospital Services (facility claims with codes not designated inpatient)

Primary		Secondary						
Code	Modifier	Code	Modifier	Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
					none			

Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)

Primary		Secondary						
Code	Modifier	Code	Modifier	Modifier Allowed	Primary Description	Secondary Description	Line Count	Secondary Paid
45385		45380	51	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	74	$25,269
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	57	$10,784
29806	SG	29807	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	3	$9,478
93505	26	93451	26	YES	BIOPSY OF HEART LINING	RIGHT HEART CATH	6	$7,290
75894	26	36005	51	YES	X-RAYS TRANSCATH THERAPY	INJECTION EXT VENOGRAPHY	14	$7,066
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONEN	PREV VISIT EST AGE 1-4	44	$6,785
98940		97140		YES	Chiropract manj 1-2 regions	Manual therapy 1/> regions	159	$6,357
22633		63047	51	YES	LUMBAR SPINE FUSION COMBINE	Remove spine lamina 1 lmbr	4	$6,333
90471		99213		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	58	$6,320
90471		99214		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	34	$5,485
36224		36222	51	YES	Place cath carotd art	Place cath carotid/inom art	4	$5,367
31267	SG	31256	SG	YES	ENDOSCOPY MAXILLARY SINUS	EXPLORATION MAXILLARY SINUS	3	$4,947
90460		99391		YES	IM ADMIN 1ST/ONLY COMPONEN	Per pm reeval est pat infant	33	$4,723
90471		99392		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 1-4	31	$4,649
22630		63047	51	YES	LUMBAR SPINE FUSION	Remove spine lamina 1 lmbr	3	$4,512
90471		99391		YES	IMMUNIZATION ADMIN	Per pm reeval est pat infant	33	$4,481
63047	51	63042	51	YES	Remove spine lamina 1 lmbr	LAMINOTOMY SINGLE LUMBAR	2	$4,185
29824	SG	29822	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	1	$3,655
97140	GP	97530	GP	YES	Manual therapy 1/> regions	THERAPEUTIC ACTIVITIES	71	$3,646
98941		97140		YES	Chiropract manj 3-4 regions	Manual therapy 1/> regions	101	$3,618
28299	SG	28270	SG	YES	CORRECTION OF BUNION	RELEASE OF FOOT CONTRACTURE	1	$3,424
28299	SG	28285	SG	YES	CORRECTION OF BUNION	REPAIR OF HAMMERTOE	3	$3,424
29824	51	29822	51	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	3	$3,331
29806	SG	29823	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	1	$3,320
72149		72148		NO	MRI LUMBAR SPINE W/DYE	MRI LUMBAR SPINE W/O DYE	1	$3,141
29827	81	29822	81	YES	ARTHROSCOP ROTATOR CUFF REP	SHOULDER ARTHROSCOPY/SURGER	2	$3,077
						TOTAL over $3,000	**746**	**$154,664**
						GRAND TOTAL	**2,297**	**$370,336**

Findings
From these limited reports, it is evident that over $150,000 has been allowed for secondary procedures that would not have been allowed by CMS (Medicare or Medicaid). Furthermore, there is more than $220,000 of disallowed procedures (with less than $3,000 of potential overpayments) also identified but are not detailed in this report.

Medically Unlikely Edits

CMS established units-of-service edits referred to as Medical Unlikely Edits (MUEs). MUEs are designed to limit fraud and/or coding errors. The MUE rule for a given CPT/HCPCS code is the maximum number of service units that a provider should report for a single day of service. An MUE is defined as an edit that tests claim lines for the same beneficiary, procedure code, date-of-service, and billing provider against a maximum allowable number of service units.

Often in an automated claims processing system, MUEs represent an upper limit that unquestionably requires further documentation to support. For example, electro-cardiogram tracing (CPT code 93005) is limited to three tests per day (3 service units) as a hospital outpatient. If the service units exceeds three (3), the individual claim line should be denied.

MUEs are generally based on biological considerations, like number of limbs or organs and are performed on units billed per line-of-service. The same code billed on different lines for the same date-of-service is subject to duplicate adjudication edits where CPT Modifiers like 59, 76, and 77 may impact the payment. MUEs do not require that Medicare contractors perform manual review or suspend claims; rather, claim lines should be denied and correctly resubmitted by the providers.

Recoveries to an employer's plan will vary, depending on the cause of the discrepancies and the accuracy of the data submitted by the provider and collected by the claim administrator. The cause of the MUE edit errors could be incorrect coding, inappropriate services being performed, or fraud. While most of the Procedure-to-Procedure Edits will result in significant recoveries, most of the MUE Edits will result in providers rebilling the procedures, causing a slightly less payment amount.

The MUE Edits provided by CTI are grouped into three separate reports:

- Outpatient Hospital Services
- Non-Facility
- Ancillary

Following are CTI's NCCI MUE Edit Reports for procedure code combinations with greater than $1,000 in potential overpayments:

MUE Edits

Greater than $1000 paid

Based on Paid Date 01/01/2013 thru 12/31/2013

Outpatient Hospital Services (facility claims with codes not designated inpatient)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
		none		

Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
88331	11	PATH CONSULT INTRAOP 1 BLOC	1	$2,223
		TOTAL OVER $1,000	**1**	**$2,223**
		GRAND TOTAL	**98**	**$11,339**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, and Non-Facility)

Procedure Code	Service Unit Limit	Procedure Description	Line Count	Benefit Paid
		none		

Common Use of NCCI Edits

It is difficult to establish the extent to which administrators and carriers are using NCCI edits as they are only mandated for Medicare and Medicaid Payers. However, CTI recommends that these reports be discussed with Cigna to determine the extent that CMS edits could be used. Use of these edits would result in a reduction of claim expenses for employers and their employees, as well as furthering efforts toward a standardized code-editing system for all payers.

Operational Review Findings and Recommendations

Claims Administrator Information

CTI seeks basic information about the Claims Administrator including background information on the administrator, financial reports, types and levels of insurance protection, dedicated staffing, claims administration systems and software, disclosure of fees and commissions, performance standards and internal audit practices. CTI offers the following observations relative to this portion of the Operational Review:

- Cigna has complied with the standards of the American Institute of Certified Public Accounts (AICPA) through issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization, which replaces the prior SAS 70 Report. Under SSAE 16, Cigna is required to provide its own description of its system, which the service auditor validates. Cigna's external auditor, PricewaterhouseCoopers LLP, did not note any deviations in the Eligibility and Enrollment, Claims, and Financial Services Controls.
- Cigna states they maintain a $50 million Fidelity Bond; however, copies of the policy face pages were not provided to CTI for verification.
- Cigna provided its self-reported results for measures subject to various performance guarantees through November 2013. Results for 2013 were not available at the time Cigna responded to CTI's questionnaire. CTI notes, however, that the performance guarantee for claim accuracy is 98%. In two of the calendar quarters for which results were available, Cigna exceeded this goal by more than 1.5%. The State of Montana may wish to consider revising the goal upward at the time the contract is renegotiated to provide Cigna a more challenging goal for guaranteed performance.
- CTI notes that the performance measure for determining acceptable financial accuracy is 98%. Based on the State's annual paid claims of more than $89 million, Cigna could make errors of up to $1.7 million per year and still meet the performance guarantee. Performance also is measured at the "Office Level" meaning results reported are not unique to the State's claims. The State of Montana may wish to consider revising the goal upward at the time the contract is renegotiated to provide Cigna a more challenging goal for guaranteed performance.
- Cigna uses its proprietary Proclaim system to process the State's claims. Proclaim was originally implemented in 1983.
- Cigna's business continuity plan includes a description of critical processes that must be addressed in the event of a disaster including timeframes for recovery of operations, identification of vital records, communication plans and off-site operations.

- The State is supported by a dedicated account team of eight customer service associates who have median tenure at Cigna of seven years.

Administrator's Claim Fund Account

CTI obtains information specific to controls and procedures related to claim checks including claim funding, fund reconciliation, handling of refunds and returned checks, large check approval, security, disposition of stale checks and appropriate audit trail reports, and COBRA and Retiree/Direct Pay premium collection. CTI offers the following observations relative to this portion of the Operational Review:

- Cigna has appropriate levels of security and control within its claim funding and check issuance procedures to protect State interests and to ensure that transactions are performed by only authorized personnel.
- Cigna uses pre-payment high dollar claim review procedures for claims above specified dollar amounts based on processor experience. Designated high dollar processors review claims over $99,999.99. Claim payments in excess of $250,000 are reviewed by a quality panel with representatives from all departments.
- Cigna does have procedures in place to separate duties and limit access to eligibility maintenance, provider maintenance, and claim adjudication functions.
- Cigna credits refunds to State claims account. All refunds are processed using the gross recovery amount. As refunds are processed in the claim system, the entire amount of the refund is credited back to the client through the normal banking process and is documented on the policyholder's monthly check register.

Administrator's Claim Adjudication and Eligibility Maintenance Procedures

CTI obtains information specific to the controls and procedures used by the administrator related to enrollment, eligibility maintenance and processing of claims. Gathered in this questionnaire is information regarding claims processing and eligibility maintenance workflow, preferred provider organizations, pursuit of claim reimbursements from third parties, physician fee allowance (UCR) data source, coding schemes used for diagnosis and procedure codes, and hospital admission and case management protocols.

CTI tests the administrator's controls and procedures by selecting specific claim cases processed during the audit period. For this audit a total of 30 candidate cases were selected and Substantive Testing Questionnaires were prepared for each and sent to Cigna for completion. A CTI auditor reviewed Cigna's questionnaire responses and supporting documentation while on-site at its facilities in Bourbonnais, Illinois. Copies of Cigna's responses to the questionnaires can be found in the ESAS® Specific Findings Report.

The population of claims electronically screened is defined as all the State's claims paid, or denied, including adjustments, voids and reversals during the prescribed audit period regardless of the incurred date of the claim. The audit period for this audit was

January 1, 2013 through December 31, 2013. The universe of Paid Claims electronically screened was:

Total Paid Amount	$89,413,284
Total Number of Claims Paid/Denied	331,817

CTI offers the following observations from its analysis of Cigna's responses to this section of the Operational Review Questionnaire and from the responses gathered through our Substantive Testing Questionnaires:

- Cigna has adequately documented training, workflow, procedures and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Cigna attempts to keep coordination of benefits information current by soliciting other insurance information on a rolling 12 month basis. When other insurance information is unknown and the claim is under $500, Cigna will pay the claim and request other insurance information from the insured. If the payable amount exceeds $500, the claim is pended and other insurance information is requested from the insured. The claim will deny if no response is received within 90 days of the request.
- Cigna uses the same process and vendor to investigate claims that may be reimbursable under workers' compensation as used for subrogation
- Cigna uses the maximum reimbursable charge, option 2 (MRC2) to limit out-of-network charges. The MRC2 fee schedule is developed by Cigna and is based on a methodology similar to that used by the Centers for Medicare and Medicaid Services (CMS) to determine fees for services within a geographic market.
- Approximately 93.8% of total claims are submitted electronically for the State plans.
- Cigna does not pursue overpayments less than $50, which is a higher threshold than used by most other administrators, based on CTI's experience.

HIPAA Compliance

CTI obtains information specific to the process the administrator has implemented in order to become compliant with the HIPAA regulations. The objective of this questionnaire segment is to determine if the administrator is aware of the HIPAA regulations and is compliant.

- Cigna has appropriate levels of security and controls in place to protect State plan records and data and is compliant with HIPAA requirements.

- Cigna is compliant with all required HIPAA compliant electronic transactional requirements.

Preferred Provider Utilization and Savings

According to the data received, during the audit period, Cigna achieved 20.2% off billed charges as a discount on in-network claims. CTI observed several in-network claims that were paid at billed charge and when tested, Cigna responded that the claims were paid correctly as the provider was billing at or below the contracted rate.

Claim Technologies Incorporated

Provider Discounts for Montana State - CIGNA

Based on Paid Date 01/01/2013 thru 12/31/2013

Total of All Claims

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$4,217,951	$688,938	16.3%	$2,480,775
Non-Facility	$57,199,264	$16,062,286	28.1%	$30,457,183
Facility Inpatient	$32,897,333	$6,625,921	20.1%	$23,483,608
Facility Outpatient	$46,453,489	$5,273,563	11.4%	$32,991,717
Total	**$140,768,038**	**$28,650,708**	**20.4%**	**$89,413,284**

In-Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$3,595,071	$535,652	14.9%	$2,222,320
Non-Facility	$55,248,863	$15,425,545	27.9%	$29,984,421
Facility Inpatient	$32,284,120	$6,552,122	20.3%	$23,186,967
Facility Outpatient	$45,577,088	$5,147,832	11.3%	$32,646,937
Total In-Network	**$136,705,142**	**$27,661,151**	**20.2%**	**$88,040,644**
% of Allowed Charge	97.1%			
% Claim Frequency	91.7%			

Out of Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$622,880	$153,286	24.6%	$258,456
Non-Facility	$1,950,402	$636,741	32.6%	$472,762
Facility Inpatient	$613,213	$73,800	12.0%	$296,641
Facility Outpatient	$876,401	$125,731	14.3%	$344,781
otal Out of Network	**$4,062,896**	**$989,558**	**24.4%**	**$1,372,640**
% of Allowed Charge	2.9%			
% Claim Frequency	8.3%			

Secondary

Claim Type	Allowed Charge	Provider Discount		Paid
Ancilliary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Allowed Charge	0.0%			
% Claim Frequency	0.0%			

Allowed Charge = Provider Discount + Deductible + Copayment + Coinsurance + Paid Amount

Facility Inpatient = Any claim with a Room and Board Revenue Code (100-219)

Facility Outpatient = Any claim with Revenue Codes not Flagged as Inpatient

Non-Facility = Any claim with CPT Codes: 00100 - 99999

Ancillary = All other claims not flagged in Inpatient, Outpatient and Non-Facility

Exhibit A

Operational Review Questionnaire and Responses

(Copies of Cigna's supplemental responses are available upon request.)

Operational Review Questionnaire

for

Comprehensive Claim Administration Audit

of

State of Montana
Medical Benefit Plan

- **Part A – Claims Administrator Information**
- **Part B – Administrator's Claim Fund Account**
- **Part C – Administrator's Claim Adjudication and Eligibility Maintenance Procedures**
- **Part D – HIPAA Requirements**

Date Sent: November 20, 2013

Part A: CLAIMS ADMINISTRATOR INFORMATION

1 Name of Administrator: Cigna HealthCare

2. Number of years serving this/these plans:

☑ 5 or less years ☐ 5-10 years ☐ 10 years or more

3. Number of clients for which you process medical claims:

☐ Less than 10 ☐ 10 to 50 ☑ 50 or more

4. Employee Crime Policy/Fidelity Bond

a. Please provide the declarations page of the Crime Policy (or Fidelity Bond) for your employees. Copy provided?

☑ Yes ☐ No

Microsoft Word Document

b. If not provided, please explain:

c. Are your employees subject to background checks to screen for felony convictions?

☑ Yes ☐ No

5. Employee Confidentiality:

a. Are your employees required to sign agreements that restrict them from disclosing confidential information relating to the insureds covered by this plan?

☑ Yes ☐ No

6. Errors & Omissions Policy:

a. Please provide a declarations page for your Errors & Omissions Policy. Copy provided?

☑ Yes ☐ No

b. If not provided, please explain:

Due to the confidential nature of the contract between Cigna and our insurers, Cigna is not able to supply CTI with a copy of the declaration page from the E&O policy. Cigna will be happy to discuss the Errors & Omission Standard Operating Procedures with CTI during the on-site visit.

7. Other Compensation:

a. Are all agreements for fees or commissions to all parties receiving compensation from these plans known to the client?

☑ Yes ☐ No

8. Conflict of Interest:

a. Does your firm or do any officers of your firm have any interest in any organizations which offer services to this plan or its participants?

☐ Yes ☑ No

b. If Yes, please identify parties and provide brief explanation:

9. Performance Standards

a. Are there performance standards in place for the administration of this client's eligibility (including ID card issuance), claim adjudication, customer service?

☑ Yes ☐ No

b. If Yes, please provide a copy of standards. Copy provided?

☑ Yes ☐ No

State of Montana 03335407.pdf ...

c. If Yes to a. above, provide a copy of the report or reports of your performance during the audit period. If the audit period spans more than one performance guarantee period, provide reports from both periods. Copy provided?

☑ Yes ☐ No

Please see 9b

d. If Yes to a. above, and if you did not perform at or above minimum levels of performance, has a credit for the period or periods been issued to the client?

☐ Yes ☑ No

Medical – Time to Process in 14 calendar days is measuring 92.9%. The goal is 96% in 14 calendar days. Year end results have not yet been delivered.

e. If Yes to d. above, how much was the credit and in what form and when was it issued to the client?

The penalty is .30 PEPM. Medical TTP at 92.9% will result in a 50% penalty (.15 PEPM). The credit has not been delivered. Once year end results are finalized a check will be delivered to The State of Montana.

10. Financial Report:

a. Please provide a copy of your most recent audited financial report. Copy provided? ☑ Yes ☐ No

b. If not provided, please explain:

Cigna's financial report can be reviewed on the internet at:
http://www.cigna.com/about_us/investor_relations/recent_disclosures.html

11. SSAE – 16 Audit:

a. Has an SSAE–16 audit been performed on your organization in the past two years? ☑ Yes ☐ No

b. If Yes, please provide a copy of the SSAE–16 audit report. If not provided, please explain.

The SSAE 16 report is issued annually representing the period from October 1st through September 30th of the following year. PricewaterhouseCoopers conducts this review.

A copy of the most recent report has been sent to CTI under separate email.

12. Additional Documents Required:

Please provide a copy of each of the following documents:

a. The master policy/plan document. Copy provided? ☐ Yes ☑ No

Please refer to The State of Montana for this information.

b. The summary plan description/policy certificate(s) applicable to the audit period for each plan. Copy provided? ☐ Yes ☑ No

Please refer to The State of Montana for this information.

c. Copies of any memos or letters authorizing plan exceptions and/or changes to benefits. Copy provided? ☐ Yes ☑ No

Information relative to any exceptions in conjunction with specific claims in the audit sample will be provided during the onsite review.

d. Amendments that affected claim payments during the audit period. Copy provided? ☐ Yes ☑ No

Please refer to The State of Montana for this information.

e. The Administration Agreement between you and the client during the audit period. Copy provided? ☐ Yes ☑ No

Please refer to The State of Montana for this information.

f. A printout of system benefit parameter setup used to adjudicate this client's claims. Please include any changes made during the period of audit. Copy provided?

☐ Yes
☑ No

Cigna's benefit loading screens are considered proprietary and not able to be shared.

13. System Software:

a. What software is used for your claim administration system:

The State Of Montana's medical claims are processed on Cigna's Proclaim claim system.

b. What is the name of the Software Vendor:

Proclaim is a sophisticated on-line claim processing system developed and owned by Cigna

c. How long have you been using this software and claim system?

Proclaim was acquired by Cigna with the acquisition of Healthsource in the Mid-1990's. Proclaim was implemented in 1983. It is an in-house designed and developed claim payment system.

d. What software is used within your claims system to detect "unbundling" of services:

Cigna uses ClaimCheck®, a clinically based software system to help prevent costly billing errors and improve claim review speed and efficiency. ClaimCheck® detects coding irregularities, conflicts, and errors and makes correction recommendations. The system also identifies cosmetic, unlisted and duplicate procedures.

e. How long have you been using this "unbundling" software?

Cigna has been utilizing ClaimCheck® since 1989. It was fully automated in 1996.

14. Business Continuity Plan:

Briefly explain what systems are in place for protecting data in case of a disaster or other business interruption. Also, describe frequency of system back-ups, and type of storage facility used to house back-up data.

Please see attached for an overview of Cigna's Business Continuity Programs.

Microsoft Word Document

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Dedicated Staffing

a. Is there a staff of people in your company dedicated to providing account services, claim or customer service to this client?

☐ Yes
☑ No

b. If Yes to a. above, please list staff by name and give titles, brief description of responsibility to client, years of experience in the position they are in, years of service in dedicated capacity to this client.

The following staff are dedicated to The State of Montana:

Name	Title	Tenure
Sheri French	Service Coordinator	1 year
Lynn Morrison	Nurse Case Manager	1 year

The State of Montana is serviced by a designated call and claim team.

Call Staff:

The State of Montana call staff is comprised of 6-8 CSAs who support The State of Montana during the core hours. The median tenure of this team is 7 years.

Claim Staff:

Name	Title	Time on job
Tyra Barrera	Claims Processors	2.5 years
Melinda Butler	Claims Processors	2.8 years
Nancy Capps	Claims Processors	1.7 years
BeLinda Engler	Claims Processors	3.5 years
Angie Gillis-Cronsell	Claims Processor SR Assoc	13.5 years
Melissa Jordan	Claims Processors	1 year
Yasmine Parra	Claims Processor Sr Assoc	1.7 years
Gayle Knauth	Claims Processors	2.7 years
Tiata Knight	Claims Processors	3.5 years
Samantha Madison	Claims Processors	2.7 years
Kimberly Szakmary	Claims Processor Sr Assoc	12.4 years

16. Off-Site Claim Administration

a. Was the claim processing function outsourced to any subcontractor for this client during the period to be audited? ☐ Yes ☑ No

b. If "Yes", please explain:

17. Off-Site Member/ Provider Services

a. Were either the member or provider services functions outsourced to any subcontractor for this client during the period to be audited? ☑ Yes ☐ No

b. If "Yes", please explain:

During the audit scope period, Cigna utilized the following two vendors only for provider call handling; Convergys. Customer calls continue to be handled by Cigna.

Part B: ADMINISTRATOR'S CLAIM FUND ACCOUNT

18. Use of Checking Account:

a. Are claim checks issued on a checking account of the administrator or the client? Initial claim payments are issued through Cigna's checking account. Funding is then deducted from The State of Montana's checking account on a check cleared basis. ☑ Administrator ☐ Client

b. If claim checks are issued on the administrator's checking accounts, is this checking account used for other employer or groups' claim checks? ☑ Yes ☐ No

c. If No, is this checking account used for other plans (e.g., dental, vision)? ☐ Yes ☐ No

d. Is this checking account used for any purpose other than for claim checks? ☐ Yes

e. If Yes, please explain: ☑ No

f. Are commissions, fees, or any other expenses paid from this account? ☐ Yes ☑ No

19. Reconciliation of Claim Checking Account:

a. Who performs reconciliation of claim checking account?

☑ Administrator
☐ Client

20. Refunds And Returned Checks:

a. How are refunds and returned checks credited back to the client's claim fund?

Recoveries are processed in Cigna's claim systems at the gross level. This ensures that a member's claim history is accurate and complete. As the refunds are processed in the claim system, the full amount of the refund is credited back to the client through the normal banking process and is documented on the policyholder's monthly check register.

21. Stale Checks:

a. How are stale checks credited back to the client's claim fund?

As funding is provided by the State of Montana on a cleared check basis, no funds would need to be credited back to The State of Montana for stale checks as they have not been cashed.

22. Large Check Approval:

a. Do claim checks over a pre-determined level require an additional review and approval before issuance?

☑ Yes
☐ No

b. If Yes, please describe what review is required and at what check amount? $

Tier One – up to $4,499
Tier Two – up to $14,999.99
Tier Three – Up to $14,999. Note: Senior tier three processors with proven quality records can have a $24,999.99 limit.
High Dollar Processor – Up to $99,999.99

Claims above the processor's limit require pre-pay review by a Quality Reviewer (QR). QR's have a payment limit of $199,999.99. Special high dollar QR's (limit 2 per claim office) can pay amounts over $199,999.99.

c. Describe, or provide a copy of the checklist of items that the above approval is required to entail (e.g., Does the approver review the claim to ensure claimant eligibility, no other insurance, no subrogation potential, proper referral under the plan, other?).

The initial claim processor will handle all aspects of claim processing up to the point of finalization. Since the amount of payment is in excess of the processor's authority level, the claim will then be pended to route for quality review. For high dollar, pre-payment reviews, the quality auditor will review the claim for accuracy, release it if it is correct, or correct any error and then release the claim.

d. Do claim checks over a pre-determined level require more than one signature? ☐ Yes ☑ No

e. If Yes, please describe what review is required and at what check amount? $

f. What is the policy for approval of large checks over a certain level or for a second signature if the person with that authority is not in the office when the signature is required?

N/A

23. Security:

What type of security does claim system have relating to:

a. Secured log-on passwords and system authorizations?

All authorized employees are assigned a unique password and log-on ID to access Cigna's LAN. Access to claim payment and call tracking systems are protected by an additional password log-on for each system.

Payment authorization limits (see 22b above) are directly integrated into log-on security for the claim system.

All passwords require mandatory periodic updates.

b. Authorized check signature?

Cigna uses an on-demand printing and delivery process rather than storing pre-printed checks. Checks are printed on blank check stock and sorted by ZIP code delivery location within 24 hours and mailed from the Easton, PA distribution center. Special software controls the signature plate, and allows only authorized employees to print checks.

c. Separate duties and limit of access to eligibility maintenance, provider maintenance, claim adjudication?

Access to Cigna information is granted via Role-Based Access Controls (RBAC). It is a process that defines the access an individual employee has to Cigna's information systems, based on the functions the employee performs in his or her job.

For security reasons, the ability to add or change provider screens is limited to Cigna's Network Operations/Provider Data Management team.

Claim processing and customer service personnel can view eligibility information, but do not have update capabilities.

d. Authorizations to override system edits and limitations?

Once reviewed and approved by a medical consultant, claim processors can override claim system flags such as suspected duplicates and charges exceeding any usual and customary allowances. Claim center managers receive detailed reports on override transactions, including the date and claim processor involved to help detect abuse or incorrect processing procedures by a claim processor.

24. Check Processing:

a. Are claim payments to providers batched (multiple patient accounts paid on one check to the provider on a designated time schedule)?

☑ Yes ☐ No

b. If Yes, what is the schedule for releasing batch payments?

The schedule varies by provider, but is generally weekly. Individual claim reimbursements for one provider are stored in the system. Each week on the provider's specified day, all of the reimbursements are sent to that provider on one 'bulk' check.

The explanation of benefits to the provider lists the same information for each patient that would have been received if the checks were mailed individually.

c. Is assignment of benefits honored for payment of claims from non-Network or non-participating providers?

☑ Yes ☐ No

d. If No, what controls are in place to validate the authenticity of a claim that is resulting in a check being issued to an employee?

25. Direct Pay (COBRA & Retirees) Premium Accounting:

a. Are premiums for COBRA & Retirees collected by the administrator or by the client?

☐ Administrator ☑ Client

Part C: ADMINISTRATOR'S CLAIM ADJUDICATION AND ELIGIBILITY MAINTENANCE PROCEDURES

26. Claim Administration Workflow:

a. Please provide a general workflow for a typical claim submitted for payment under this client's plan from date the claim is sent (include location claims are sent to) to date the Explanation of Benefits is sent to the member. Include locations and departments through which the claims are routed and how the claim is tracked during the workflow process.


Claim
orkflow.26.pdf (12 KI

27. Eligibility Changes:

a. Who is responsible for making updates to the list of eligible employees and dependents in your claims payment system?

Cigna receives a weekly eligibility file with any changes. That file is loaded into our eligibility system which feeds into the claim system.

b. Which medium is used to transfer eligibility changes and new additions from the employer to you?

☑ Electronic ☐ Paper forms

c. How frequently is your system updated for eligibility changes, additions, and terminations?

Cigna updates our file once a week with any eligibility changes, additions or terminations. If any manual requests come through, then that frequency may extend beyond once a week

28. Investigating Dependent Eligibility:

a. Provide a copy of your administrative procedures for verifying the continued eligibility for dependents over the plan's limiting age (e.g., handicapped dependents). Copy provided? ☑ Yes ☐ No

The State of Montana is responsible for the initial transmission and update of disabled/handicapped status.

.

b. Provide a copy of your procedures for recognizing and investigating dependents who may not be eligible for coverage (e.g., grandchildren). Copy provided? ☐ Yes ☑ No

The State of Montana is responsible for this function. Claims are processed in accordance with eligibility information provided to Cigna.

29. Hours Bank:

a. Is there an "hours bank" or other continued eligibility system for participants who are not working? ☐ Yes ☐ No

b. If yes, how does it work?

Please refer to The State of Montana for this information.

30. Other Insurance Coverage Investigation:

a. Provide a copy of your administrative procedures for the initial and continued verification of the existence of other group insurance that may be primary over the plans being audited for dependents. Copy provided? ☐ Yes ☐ No

b. If not provided, please select one of the options below that most precisely describes your corporate policy:

☐ Investigative letters sent by the claims administrator to the employee no less than once per 12 month period, or upon receipt of a dependent claim.

☐ No investigative letters sent, claims administrator uses information regarding other primary insurance from the provider via the claim submission, from the employee by phone, or from the employer.

☑ Other – please describe:

If Cigna has record of Other insurance (OI) and the Explanation of Benefits (EOB) is attached, we coordinate benefits with the other carrier.

If Cigna has record of OI and the EOB is not attached, our process is to adjudicate the claim and enter a remark code that communicates to the member/provider that the other carrier's EOB is necessary in order to process the claim.

If Cigna has confirm the non-existence of OI via recent prior investigation or as indicated on the claim form the claim is processed primary.

If existence of OI in unknown and the payable amount is $300 or more, the claim is pended. An investigational letter is sent to the insured requesting information regarding the potential existence of OI. Once this information is received, the final adjudication of the claim can proceed. If the information is not provided, at 90 days, the claim is either paid or denied based on the client's selection. The State of Montana is setup under the Deny at 90 days process

If existence of OI in unknown and the payable amount is under $300, the claim is paid as primary and a request is made to the insured for updated COB information.

COB investigation is performed on a rolling 12-month basis (or more frequently if new or conflicting information is received) with follow-up every 30, 60 and 90 days.

c. How does your system define and calculate COB savings?

COB savings is defined as the amount a plan would have paid as primary less the amount the plan did pay as secondary.

d. Provide a copy of a report showing the COB Savings for this client for the past 24 months based on the above definition? Copy provided? ☐ Yes ☑ No

COB savings information has been requested and will be provided to CTI under separate cover once available.

31. Usual, Reasonable and Customary Pricing:

a. What is the source of your Usual, Reasonable and Customary Database? (e.g., Ingenix, ADP, Proprietary)

The State of Montana utilizes maximum reimbursable charge, option 2 (MRC2) to limit out of network charges. The MRC2 fee schedule is developed by Cigna and is based on a methodology similar to that used by the Centers for Medicare and Medicaid Services (CMS) to determine fees for services within a geographic market.

b. What is the date of your most recent update? 6/20/2013

c. At what percentile is UCR set? ☐ 60th ☐ 80th ☐ 90th

Other 110%

32. Data Codes:

What coding schemes do you use for the following data elements:

a. Provider Identification Number ☑ Tax

Other

(1) Do you use a suffix on the provider ID? ☑ Yes ☐ No

(2) If yes, describe:

A four digit suffix is used in the Proclaim system.

b. Employee Identification: ☑ Social Security Number

Other Alternate member identification (AMI) numbers may also be utilized for claim submissions

c. Dependent Identification: ☐ Social Security Number

Other Employee's Social Security Number

d. Procedure Codes: ☑ CPT ☑ HCPCS

Other

e. Diagnosis Codes: ☑ ICD-9

Other ICD-10

(1) How many diagnosis codes are recorded for each claim line? 5 codes per claim

33. Claim Adjustments:

a. How do adjustments to correct claim payments appear in the claim system?

Adjustments are performed on the original claim number and the entire claim is re-processed. The claim system will reflect the most current processing of the claim. Prior claim processing details will be reflected on historical screens.

b. Provide a list of adjustment codes and their descriptions that are used to explain the adjustment of a previously adjudicated claim. Provided? ☐ Yes ☑ No

This information will be provided during the on-site audit.

34. Remark/Explanation Codes:

a. Provide a list of remark/explanation codes and their descriptions that are used to explain the denial of a claim (i.e. duplicate payment, request information, eligibility issues). Provided? ☐ Yes ☐ No

This information will be provided during the on-site audit.

35. Claim Submission Methods:

a. Are any of your claims submitted electronically from providers? ☑ Yes ☐ No

b. If Yes, approximate % of total claims submitted electronically for these plans: 93.8 %

c. How are electronically submitted claims identified differently in your system?

Electronically submitted claims are identified by Claim Control Number format

d. For manually submitted paper claims, how do you validate the authenticity of the claim?

Claim forms are not required if the claim contains all the necessary member's identifying information. Claim submissions are considered correct and valid unless there are obvious alterations or omissions. Claim and call personnel are taught to identify potential fraudulent practices. Some of which includes to look for "Red Flags" or suspicious activity. Claims fitting these criteria are pended and referred to a claim investigator.

36. Overpayment Recovery:

a. Do you have a minimum dollar amount of overpayment under which you will not pursue overpayment recovery? (i.e. if you identify an overpayment of less than $25 you will not take action to recover that overpayment.)

☑ Yes ☐ No

b. If Yes, what is the minimum dollar amount?

$ 50.00

37. Participating Provider Networks and Global Contracts:

a. What are the name(s) of any Global Contracts that provide additional discounts or savings to this plan:

OAP with TPV in Montana (Allegiance)

b. What are the name(s) and geographical territories covered by the provider networks used by these plans:

These can be made available during the on-site visit as needed. The data file shared in preparation for the audit does contain indication as to whether or not the claim was for an in-network provider.

c. Will the original contracts with participating providers be made available to CTI's auditors while they are on-site for the field audit?

☐ Yes ☑ No

During the onsite review, Cigna will provide access to contracted rate information in our on line claim system to assist the auditor with validation of claim payment.

d. What % of the claims come from participating providers and global contracts? ____ %

This information has been requested and will be provided to CTI under separate cover once available.

e. Provide available reports showing participating provider savings, percent of claims dollars discounted in-network, percent (frequency) of claims discounted by in-network providers for the audit period. Reports provided?

☐ Yes ☑ No

Provider savings information has been requested and will be provided to CTI under separate cover once available.

38. Subrogation:

a. Which of the following best describes your policy for pursuing details regarding a claim that has the potential for subrogation or right of recovery?

☐ Pend the claim and seek accident details and/or a signed subrogation agreement with payment only after receipt of both items.

☑ Pay the claim and subsequently follow up on accident details and/ or a signed subrogation agreement.

☐ Other, please explain:

b. Explain how the client is informed of any recoveries experienced by subrogating claims. Reports? Frequency of Reports?

All recoveries are processed through the claim system at the gross level ensuring the customer's claim history is accurate and complete. When refund processing is completed in the claim system, the credit is passed back to the policyholder's group experience via banking and billing procedures. Any credits applied reflect on the policyholder's monthly statement.

c. Do you outsource subrogation recovery? ☑ Yes ☐ No

d. If the subrogation function is NOT outsourced, do you have a dedicated Subrogation Unit or personnel to investigate and follow up on subrogatable claims? ☐ Yes ☐ No

e. If Yes, what is the name and address of the outsource firm?

Xerox Recovery Services Group (formerly knows as ACS Recovery Services)
1301 Basswood Road, Ste 105
Schaumburg, IL 60173

f. If you outsource subrogation recovery activity provide a copy of your internal policies and procedures for referring cases to the outsource firm and for follow-up on recovery status. Copy provided? ☑ Yes ☐ No

Third Party Liability investigation is handled by Xerox Recovery Services Group. They will investigate claims that total over $500.00 in paid benefits. Xerox identifies and recovers on subrogation cases and follows up on overpayments flagged by internal audits. The vendor performs an automated analysis of claims data based on a review of ICD-9-CM diagnosis codes, as well as treatment costs and demographics associated with individuals, and any related claim matters. When the system identifies claims with recovery potential, it opens an electronic file for that case. The vendor then investigates through questionnaires and phone calls to confirm recovery potential. If confirmed, the vendor proceeds to assert recovery rights.

Additional details may be supplied during the onsite review as needed

g. Provide your or your vendor's activity report showing all open and closed subrogation cases during the audit period. If the case was closed indicate the amount and date of recovery received. Copy provided?

☐ Yes ☑ No

Subrogation activity reporting for the scope period has been requested and will be provided to CTI under separate cover once available.

h. Is there a minimum dollar amount under which you will not pursue subrogation recovery? (e.g., If the claim payment is less than $500, you will not pursue subrogation.)

☑ Yes ☐ No

i. If Yes, what is the minimum dollar amount? $ 500.00

j. Do subrogation recoveries result in claim adjustments in your claim system?

☑ Yes ☐ No

k. If Yes, is there an adjustment code in your system that allows you to track all claim adjustments made as a result of subrogation recoveries?

☑ Yes ☐ No

Remark codes will be made available during the on-site audit.

39. Work Related Claims:

a. Explain your procedures for identifying, investigating, and processing claims that may be related to a Work Related illness/injury.

If a claim is clearly marked as being work related, the claim will be denied and an explanation of benefits issued. Cigna out sources third party liability/subrogation, including workers comp claims, to a company called Xerox Recovery Services Group. At any time Xerox determines a claim may be work related, Xerox will coordinate any transfer of information with the worker's compensation carrier.

b. Are claims paid prior to investigating for potential work related causes?

☑ Yes ☐ No

If we know the claim is work related (i.e. the claim is marked as such) the claim will be denied. If unknown, Xerox will investigate on a post-payment basis.

c. Is there a minimum claim payment amount that must be issued before an investigation would be initiated?

☑ Yes ☐ No

d. If Yes, what is the amount? $ 500.00

There is no minimum on an individual claim basis; however there is a $500 cumulative paid claim threshold per condition which needs to be reached prior to an investigation being initiated

40. Lifetime Maximum Accumulations

a. If there is a Lifetime Maximum on health plan benefits under this plan, does it include prescription drug claim payments as well as all health plan benefits?

☐ Yes ☐ No ☑ NA (no Lft. Max.)

b. Describe your process and system support for accumulating the Lifetime Maximum on health plan benefits.

c. Since your company has been administering this plan, has any individual exceeded the Lifetime Maximum on benefits? ☐ Yes ☐ No

d. If Yes, please provide a list of the individuals who have exceeded the Lifetime Maximum of this plan since you have been the administrator. List provided? ☐ Yes ☐ No ☐ NA (no-one exceeded)

e. If you became the administrator of this plan's medical claims within the past five years, did you receive and accumulate claims paid by the prior administrator to the Lifetime Maximum Accumulations of this plan? ☐ Yes ☐ No ☐ NA (TPA for > 5 years)

f. If you administer more than one health plan for this employer and an employee transfers from one plan to another, do you "roll" their Lifetime Maximum Accumulations to the new plan? ☐ Yes ☐ No ☐ NA (only one plan)

41. Hospital Precertification:

a. If pre-certification of hospital admissions and/or surgery is required, who performs these functions?

Pre-certification services are performed by Cigna's Health Facilitation Department.

b. How does your system record that pre-certification was performed and the final determination?

Our Health Facilitation Department utilizes the ICMS system to document pre-certification notes and authorizations. This information downloads into the claim systems which are accessed by the claims processors.

42. Case Management:

a. Who performs large claim case management?

Cigna Case Managers located in Cigna's Health Facilitation Department perform Case Management services for The State of Montana.

b. How are claims identified for large claim case management?

Candidates are identified for possible case management through initial inpatient and outpatient pre-certifications, specific diagnoses, and specific services being rendered such as long term therapies, nursing, and transplants.

c. How are savings obtained through case management reported to the client?

Case Management savings information is shared with The State of Montana during quarterly review meetings.

43. Disease Management:

a. Who performs the disease management of chronic illness?

Cigna's *Your Health First* (YHF) coaches perform disease management services for The State of Montana.

b. How are claims identified for disease management?

Individuals are identified for the program from all available sources. The robust data gives our health advocates a 360-degree view of each person's unique health story. This data includes (but is not limited to):

- health assessment information
- health screenings data
- medical and behavioral claims data
- pharmacy claims data (from Cigna Pharmacy and external pharmacy data)
- historical information about participation in Cigna programs

potential gaps in care

c. How are disease management results reported to the client?

Disease Management program information is shared with The State of Montana during quarterly review meetings.

44. Out-of Network Negotiated Claims:

Explain or provide a copy of your internal administrative policies for discount negotiation on out-of-network claims.

Cigna contracts for claim audit and bill review services. These claim audit and services benefit the client by maximizing the savings potential on each unique claim.

Pre-payment claim review services target non-contracted providers for specific thresholds. We use the claim system to determine if claims are payable. If the claim is payable and meets the thresholds, the claim is submitted pre-payment to the vendor. The vendor utilizes their internal screening process to direct bills to one of the following service areas:

- Inpatient Repricing/Line item Analysis
- Fee Negotiation Service
- Outpatient Bill Repricing.

45. Pre-Existing Conditions:

a. Describe your procedure for investigating for pre-existing conditions.

Pre-existing condition limitations do not apply to the The State of Montana benefit plans

b. Describe your procedure for verifying Creditable Coverage Forms.

Not Applicable.

46. Telephone Inquiries:

a. Explain how telephone inquiry response time and abandonment rate is monitored.

Response time and abandonment rate is monitored on a daily basis by our Command Center and the local site Customer Service Managers.

b. Provide a copy of the report that was used to monitor telephone inquiry response time and abandoned calls for the audit period. Copy provided?

☑ Yes
☐ No

Please refer to the reports provided in response to question 9b within this document.

47. Claim Appeals:

a. Explain how the response time on claim appeals is monitored.

Cigna's National Appeals Organization (NAO) utilizes daily, weekly and monthly management reports to monitor the appeals inventory and compliance performance. These reports allow the management team to work with the staff closely to prioritize the appeals volume. These reports also allow the NAO to work closely with the matrix partners to reduce delays for getting the appeals to the NAO. The State of Montana has a two level appeal process for post service administrative and medical necessity appeals. The second level appeal is handled by The State of Montana.

b. Provide a copy of the report for the most recent 12 months that is used to monitor claims appeals response time. Copy provided?

☑ Yes
☐ No

2013 State of ontana External.

48. Claim Turnaround Time:

a. Explain how claim turnaround time is calculated.

Claim receipt date is recorded when a claim is received by Cigna. Turnaround time on 'clean' claims is based on the time elapsed from date received to date finalized.

Internal pends (additional review is required from an internal Cigna entity) are counted in turnaround time from the date received to the date finalized.

External pends (additional information is required outside of Cigna) are counted from the date received to the date pended. Once the external information is received, turnaround time is then counted based on the date the additional information was received to the date finalized.

b. Is it calculated the same way for the original claim as it is for an adjustment to the original claim?

☐ Yes
☑ No

c. If No, please explain how claim turnaround is tracked for an adjustment to an original claim.

If the adjustment is due to a Cigna controlled event, turnaround time is factored based on the original date received.

If the adjustment is due to an external factor, turnaround time is factored based on the date additional information is received.

49. Reinsurance:

a. Does this Client have a reinsurance contract?

☐ Yes
☑ No

b. If Yes, please provide a copy of the reinsurance contract(s) in force during the audit period. Copy provided?

☐ Yes
☐ No

c. If Yes, does your firm file for reinsurance reimbursements with the reinsurance carrier on behalf of the Client?

☐ Yes
☐ No

d. If Yes to c., please provide a copy of the reinsurance filing reports for any contract year that ended during the audit period and the end of the most recent month of the audit period showing reinsurance reimbursements filed for and received. Copy provided?

☐ Yes
☐ No

e. Please explain how your company reinsurance reimbursements are credited to the Client and who performs this task.

50. Provider Fraud and Abuse:

a. Does your company have a dedicated staff for monitoring provider fraud and abuse?

☑ Yes
☐ No

b. If Yes to a., please describe the staff's make-up, expertise and functions, specifically with regard to the challenge of identifying and pursuing fraud and abuse on behalf of your health care clients.

Health care fraud impacts both the cost and quality of medical coverage by increasing the cost of doing business and creating a loss of public confidence. Cigna continually strives to detect and prevent health care fraud.

Our special investigations staff provides the front line for the detection and prevention of fraud. Located in Bloomfield, Connecticut, investigators work closely with claim, legal and clinical personnel to establish new guidelines and/or enhancements that may be required.

The special investigations unit is a team of professionals with expertise in fraud investigations, law enforcement, clinical, accounting and compliance management. There are a total of 62 employees in the department.

The investigators are responsible for the following tasks:

- Conducting investigations of suspected fraud and analyzing cases to determine the scope of the potential fraud;
- Mitigating the financial impact of potential fraud by flagging providers or members in our claim systems to alert claim processors of an investigation;
- Developing evidence of potential fraud for the referral of cases to law enforcement, regulatory bodies and industry associations;
- Pursuing civil recovery against those who have submitted false claims;
- Coordinating and compiling information on savings and recovery; and

Identifying new and enhanced controls to prevent or detect fraud.

c. What efforts does your company take to take legal action against providers who have shown indication of committing fraud or abusing one of your client's plan of benefits?

Once potential fraud has been identified, a thorough investigation is conducted to determine the extent of the fraudulent activity.

If provider fraud is substantiated, the evidence is referred to a law enforcement agency or the State Insurance Fraud Bureau, as required.

d. Does your company utilize links to external reports of providers who have been indicted or sanctioned for having committed fraud (such as Medicare's database of indicted providers)?

☑ Yes
☐ No

e. If Yes to d., please list the links and resources that your company utilizes.

Cigna utilizes a multitude of resources to aid in researching provider fraud. Cigna has access to the sites of (and receives specific updates from) a variety of States' Department of Insurance and States' Attorneys General offices relating to fraud investigations and judicial actions including those in California, Pennsylvania, New York, New Jersey and others.

Additionally, Cigna is one of the founding members of the National Health Care Anti-Fraud Association (NHCAA) in which we participate in ongoing information sharing activities that identifies healthcare fraud and providers involved. The association also provides its members with a press report of all law enforcement actions on healthcare fraud matters on a weekly basis which are all reviewed and evaluated. We also review the CMS sanctions listings on an ongoing basis to identify those who have been identified by the government relative to Medicare filings.

f. Does your company utilize software designed to identify potential provider fraud?

☑ Yes

☐ No

g. If Yes to f., please list the software name and versions.

Cigna's Special Investigations unit utilizes IBM FAMS tool (Fraud and Abuse Management System) to assess specific potential fraud allegations quickly and cost effectively. SI uses the FAMS to identify potential fraudulent providers by measuring subtle variations in billing behavior, ranking providers against their peers and identifying deviations from the norm.

FAMS supports a full spectrum of antifraud and abuse activity — detection, investigation, settlement and prevention — and includes tools for basic and advanced data mining, drill-down reporting, and visualization techniques.

Part D: HIPAA COMPLIANCE

51. Privacy Compliance:

a. Has your organization signed a Business Associate agreement with this employer? ☑ Yes ☐ No

b. Have all employees with access to Personal Health Information (PHI and ePHI) been made aware of the security and confidentiality rules under HIPAA? ☑ Yes ☐ No

c. Have you taken all appropriate measures to safeguard protected health information (PHI) within your organization? ☑ Yes ☐ No

d. Have you established a procedure to report complaints of violations of HIPAA to this employer? ☑ Yes ☐ No

52. Electronic Data Interchange (EDI) Compliance:

a. Please explain how providers are currently able to send claims and inquiries to you in a HIPAA compliant EDI format.

Providers exchange all HIPAA compliant payer/provider transactions with Cigna via the following channels:

1. Traditional clearinghouse method by using products, vendors or small clearinghouses that are connected to the Emdeon Business Services clearinghouse
2. Directly with Cigna via secure internet by using free software provided by Post-n-Track.

53. Compliance With Standards For Data Security Protections:

a. Have you performed and documented a risk analysis to assess potential risks associated with your organizations receipt or transmission of electronic personal health information (ePHI) at this time? ☑ Yes ☐ No

b. Have you conducted a security audit within the past 6 months to compare your organizations current practices and technology to the HIPAA security requirements to identify gaps that must be closed? ☑ Yes ☐ No

c. Has your organization documented its rationales in instances where it has taken advantage of the flexibility in HIPAA's security requirements for meeting security specifications?

☑ Yes
☐ No

d. Please provide an overview of your organization's policies and procedures for the security of members' protected health information. Copy provided?

☐ Yes
☑ No

Cigna is committed to protecting customers' privacy and confidentiality in accordance with HIPAA Privacy regulations. We have implemented necessary procedures to support compliance with privacy regulations. Cigna's complete policies and procedures are considered proprietary information, and as such, only a summary listing our privacy-related policies and procedures may be shared with external parties.

Cigna Privacy Policy Procedure...

e. Please identify any security breaches that have been recorded and reported that affect our mutual client and covered members. Report provided?

☐ Yes
☑ No

We are not able to provide specific information regarding security incidents, as revealing that information would itself compromise our confidentiality obligations to clients. However, it is our standard practice to notify a client if any unauthorized disclosure of personally identifiable information occurs that resulted in notification to the individual impacted and/or government authorities.

ELECTRONIC SCREENING REPORT

The State of Montana Medical Plan
Administered by:
Cigna
Audit Period: January 1, 2013 – December 31, 2013

Prepared: April 28, 2014

ELECTRONIC SCREENING REPORT

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Overview

Electronic Screening Objective

The objective of our electronic screening is to identify and quantify claim administration system problems that appear to be causing payment errors.

Electronic Screening Scope

CTI performed electronic screening of 100 percent of each of the medical service lines that comprise a medical claim processed by Cigna during the 12 month period of January 1, 2013 – December 31, 2013. Cigna processed 331,817 claims (including adjustments) for 27,104 State claimants representing 907,966 separate medical service line items and resulting in $89,413,284 in payment by the plan.

A complete list of the ESAS® Screening Categories and Subcategories is shown in Figure 1. below.

Figure 1.

ESAS® Screening Categories to Identify Potential Amount at Risk				
Category	**Subsets**	**Evaluate Procedure**	**Quantify Errors**	**Reason Codes**
Duplicate Payments to Providers and/or Employees				
	Duplicates from two Claims	☑	☑	DP2A-D
	Duplicates from three or more Claims	☑	☑	DP3C
Plan Limitations				
	Specific to Plan Provisions such as: • Dollar Limitations • Number of Visit Limitations	☑	☑	PLxx
	Payments After Timely Filing Limit	☑	☑	TFLM
Plan Exclusions				
	Specific to Plan Provisions such as: • Hearing Aids • Cosmetic Surgery • Weight Loss Treatment • Dental • Nutritional Counseling •	☑ ☑ ☑ ☑ ☑	☑ ☑ ☑ ☑ ☑	EXxx DXxx
Multiple Surgical Procedures				
	Multiple Procedures Should be Reduced Fees	☑	☑	MSPC

Electronic Screening Methodology

CTI used its proprietary software, ESAS®, to screen each medical service line processed. ESAS® applies several hundred screening parameters to each line to identify claims that may be paid in error. Any service line edited by ESAS® is considered "red-flagged", meaning it has the potential for having been over- or under- paid based on the screening parameters set into ESAS® and the claim data provided by the claim administrator.

To validate ESAS® screening findings, CTI selects a targeted sampling from the "red-flagged" service lines to test. This is the targeted sampling component of our electronic screening process. Our experience has shown that this type of sampling is necessary in order to validate that the claim data provided was adequate to produce reliable screening results. While CTI is confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the electronic screening results shown below represent potential, not actual, overpayments and process improvement opportunities. Additional testing of these claims by Cigna and the State would be required to substantiate the findings and to provide the basis for remedial action planning.

CTI is not authorized to tell the Claim Administrator to recover overpaid amounts. The process and impact of recovering overpayments should be discussed by the Plan Sponsor and the Claim Administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures can be improved to eliminate future similar payment errors.

Procedures Followed

The specific procedures that were followed to complete this electronic screening and analysis of claims data for the State are as follows:

- **Document Review**

  We conducted an in-depth review of the State administrative services agreement and plan documents. These documents provided the specifications we used in setting the parameters in ESAS® and analyzing the electronically screened results.

- **Data Conversion**

  We converted claims data provided by Cigna into ESAS® database formats. The converted data was reconciled against control totals and checked for reasonableness before proceeding with electronic screening.

- **Electronic Screening**

  To the extent the claim data provided to us by Cigna supported the ESAS® algorithms, we utilized ESAS® to screen the State Plans claims data.

- **Auditor Analysis**

  If the category represented Potential Amounts at Risk and the amount "red flagged" within that category was material, our auditors reviewed the category findings to confirm that the electronically screened potential errors appeared valid

and to select the best examples of potential overpayments to conduct further substantive testing of.

- **Substantive Testing and Additional Analysis**

  For this State audit a total of 30 red flagged cases were selected and Substantive Testing Questionnaires were prepared for each and sent to Cigna for completion. A CTI auditor reviewed Cigna's questionnaire responses and supporting documentation. Copies of Cigna's responses to the questionnaires are provided in Exhibit A. (Questionnaire responses presented in Exhibit A. have been redacted to eliminate personal health information.)

  Based on the responses from Cigna and further analysis of the ESAS® findings in light of those responses, CTI removed any false positives that could be systematically identified from the Potential Amounts at Risk. False positives typically occur because certain claim data was misleading or inadequate.

- **Review of Preliminary ESAS® Findings and Reporting**
  We reviewed the preliminary findings from the electronic screening and analysis process with the Claim Administrator to ensure that we had complete understanding and agreement (where possible) on the reported results before preparing this report section and the Executive Summary.

Findings by Screening Category

This section of the report includes the ESAS® Summary report showing by category the number of line items or claims and the total potential amount at risk that remain now at the conclusion of our analysis and substantive testing protocols.

Following the ESAS® Summary report is a detailed explanation of our Substantive Testing results, findings and recommendations if it is our opinion that process improvement or recovery/ savings opportunities exist.

Note: If CTI is making an improvement recommendation, it will be denoted by a “Yes” in the final column of the ESAS® Summary reports.

ESAS - Summary (as of 04/22/2014)

Categories for Potential Amount At Risk

Client: Montana State - CIGNA
Screening Period: 01/01/2013 - 12/31/2013

Analysis Final Results

Claims Red Flagged	2,394
Claimants Red Flagged	1,636
Paid Amount Red Flagged	$748,080
Potential Amount at Risk:	$380,517

Category	Lines	Clmts	Description	Charge Amount	Paid Amount		Potential Amount At Risk Recommended Improvement
Duplicate Payments to Providers and/or Employees							
DP2A	17	6	Duplicate Payments to Providers and/or Employees	$1,062	$1,932	*	$870
DP2B	250	77	Duplicate Payments to Providers and/or Employees	$13,559	$21,932	*	$8,373
DP2C	528	178	Duplicate Payments to Providers and/or Employees	$31,923	$54,081	*	$22,158
DP2D	28	11	Duplicate Payments to Providers and/or Employees	$780	$1,480	*	$700
DP3C	12	4	Duplicate Payments to Providers and/or Employees	$364	$893	*	$529
Plan Limitations							
PL03	16	6	Chiropractic - 20 days/year	$635	$444		$441
PL04	158	12	Card Rehab/PT/OT/ST - 30 days combined/year	$19,542	$14,499		$14,488
PL05	11	1	PT/OT/ST - 60 days combined/year	$2,035	$2,035		$2,035
PL08	12	1	Acupuncture - Classic: 10 days/year	$255	$185		$186
PL09	80	78	Well Child/Adult Exam - 1 visit per year	$16,167	$14,253		$14,255
PL10	15	6	Mammogram - 1 per year ages 40+	$1,215	$952		$950
PL11	15	12	Pap - 1 per year ages 21 - 65	$842	$606		$606
PL12	8	8	Cholesterol Screen - ages 35+	$389	$229		$230
PL14	1	1	Colorectal Cancer Screen - ages 50+	$569	$359		$359
Plan Exclusions							
EX01	189	18	Acupuncture	$6,525	$2,650		$2,650
EX07	613	84	Automated Labs	$9,666	$4,891		$4,891
EX12	118	81	Exercise Equipment	$1,191	$284		$284
EX15	4	3	Hearing Exam	$322	$91		$91
EX16	6	3	Hearing Aids & Supplies	$21,287	$15,599		$15,599
EX17	26	7	Cochlear Implants, Analysis, Programming, Devices	$16,512	$6,082		$6,082
EX19	31	30	Vision Refractions	$601	$942		$942
EX23	97	47	Routine Foot Care (OK Diabetic/Vascular Insufficiency)	$5,533	$1,124		$1,124

EX24	72	57	Orthotics (Testing & Training)	$8,039	$2,861	$2,861
EX25	176	118	Orthotics	$36,205	$10,715	$10,715
EX26	1	1	Arch Supports	$50	$45	$45
EX28	14	4	Abortions, Elective	$1,703	$461	$461
EX29	113	40	Genetic Counseling and/or Testing	$49,643	$23,629	$23,629
EX38	216	65	Impotency	$15,294	$5,832	$5,832
EX40	1	1	Non-Emergency Transportation	$839	($178)	($178)
EX53	6	3	Biofeedback	$366	$94	$94
EX54	4	1	Cognitive Therapy	$1,008	$763	$763
EX57	2	2	Recreational Therapy	$1,036	$932	$932
EX58	272	152	Educational Therapy & Supplies	$28,542	$13,936	$13,936
EX59	1	1	Marriage Counseling	$125	$103	$103
EX60	49	36	Smoking Cessation	$1,348	$611	$611
EX63	424	252	Physicals, Work, Insurance, School	$30,286	$24,517	$24,517
EX64	53	26	Massage Therapy	$1,590	$513	$513
EX68	20	14	TMJ - Temporomandibular Joint Disorder	$4,939	$2,407	$2,407
EX70	43	16	Weight Loss Surgical Treatment	$44,485	$10,197	$10,197
EXC1	2	1	Abdominoplasty (Cosmetic)	$2,029	$1,446	$1,446
EXC2	1	1	Dermabrasion (acne scarring, wrinkle removal)	$75	$0	$0
EXC4	6	3	Breast Reduction (Female, also Gynomastia in Males)	$30,480	$11,798	$11,798
EXC6	3	1	Cosmetic Surgery (Plastic-Excessive Skin Removal)	$4,047	$1,780	$1,780
EXC8	5	3	Eye Surgery (Cosmetic) Blepharoplasty	$6,342	$3,004	$3,004
EXCF	57	27	Varicose Vein Treatment (sclerosing solutions)	$20,562	$9,964	$9,964
Multiple Surgical Procedures						
MSPC	721	287	Multiple Surgical Procedures Should be Reduced Fee	$712,682	$494,378	$157,244

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

Exhibits

A. Substantive Testing Questionnaire Responses and CTI Conclusions

B. Cigna Final Response to Working Draft Report

Exhibit A.

Substantive Testing Questionnaire Responses and CTI Conclusions

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	1
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Please see bill attached. Two separate services rendered same day.

Conclusion

No procedural deficiencies identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

No payment error identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	2
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Please see bills attached. Service was performed on two separate occasions in connection with two separate outpatient procedures.

Conclusion

No procedural deficiencies identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

No payment error identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	3
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Please see bills attached. Services were rendered on two separate occasions in connection with two separate Outpatient procedures.

Conclusion

No procedural deficiencies identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

No payment error identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Duplicate Payments to Providers and/or Employees

Substantive Testing Questionnaire

Questionnaire ID:	4
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having potential duplicate claim payments.

The claims listed below appear to be duplicates. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing duplicate claim payments.

2. A copy of each bill.

3. If the listed claim(s) are duplicates, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Please see attached bills. Services reflect treatment for different conditions, submitted under different patient account numbers, indicating separate services on same day.

Conclusion

No procedural deficiencies identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

No payment error identified. Charges are not duplicates. Any other claim can only be considered correct when a procedure that is billed multiple times is valid.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	5
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for cardiac rehabiliation, occupational therapy, physical therapy, and/or speech therapy have not been exceeded based on the plan limitations.

Administrator's Response

State of Montana plan includes a 30 visit short term rehabilitation benefit (not including chiropractic care which has a 20 day limitation). Please see claim history for visits incurred. Short term rehab has been reached, but not exceeded. Chiropractic benefit has not reached.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Limitations

Substantive Testing Questionnaire

Questionnaire ID:	6
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are limited under this Plan.

1. The claims relating to charges for the plan limitation in question are listed below. Please provide documentation showing that the benefits for routine exam have not been exceeded based on the plan limitations.

Administrator's Response

In-Network preventive care is payable at 100% and is not subject to a visit dollar maximum.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	7
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for othotics services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by HCPCs Code. Code L3020 does not require review (per cpt code list as part of Cigna's standard operating procedures). Service is for custom molded orthotic for a medical condition.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	8
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for elective abortions services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by procedure and diagnosis codes. Please see bill attached. Medical condition present. Services were therapeutic, not elective in nature.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	9
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for impotency services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by CPT and procedure codes. Please see bills attached reflecting a medical/surgical treatment was performed (Additional diagnosis on bill) vs. for impotency.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	10
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for physicals for work, insurance, or school services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by CPT and diagnosis code. The CPT code billed is listed on the Preventive Code list and are payable w/a wellness diagnosis or any other diagnosis billed. Diagnosis code billed does not state services were performed specifically under an order form work or school.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	11
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for weight loss surgical treatment services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by CPT and diagnosis codes billed. Claim submission was approved based on exception from client. Customer was on select list of customers provided by the State for approval. See exception on file.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	12
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for breast reduction services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by CPT code. Procedure code 19318 requires prior auth/medical necessity review. Services are covered if deemed medically necessary. Services were approved upon review - Auth BOSQK8R on file.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Plan Exclusions

Substantive Testing Questionnaire

Questionnaire ID:	13
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim payment(s) for conditions which are excluded under this Plan.

The claim(s) for the treatment in question are listed below. Please respond to the following:

1. How are claims for blepharoplasty services identified and investigated?

2. Provide the documentation that supports the payment of these claims.

Administrator's Response

Services are identified by CPT code. Procedure code 15823 requires prior auth/medical necessity review. Services are covered if deemed medically necessary. Services were approved upon review - Auth BOZMMGKI on file.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Invalid Procedure Codes

Substantive Testing Questionnaire

Questionnaire ID:	14
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claims payments for procedures in which an invalid CPT procedure code was used and would warrant further investigation prior to claim payment.

The following are the list of claims with the offending procedure code(s). Please provide the following:

1. Documentation of the procedure actually performed and billed as listed below.

2. How was the coverage of and benefit allowance determined for this procedure code(s)?

Administrator's Response

14A - R: Please see lifesource expense grid attached. The claims in question are for a transplant member on the American Express reimbursement program. The member is issued an American Express card to be used for Travel and Lodging. Cigna reimburses American Express on a monthly basis. This special processing is handled by the transplant team using bulk reports, there is not an individual claim submission.

14G: Please see bills attached showing services rendered and billed. Services are a component of a heart transplant inpatient stay. Allowance made based on provider's Lifesource contract for transplant.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Subrogation/Right of Recovery from Third Party

Substantive Testing Questionnaire

Questionnaire ID:	15
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for condition(s) for which investigation into the potential for Subrogation and/or the exercise of the Right of Recovery provision was warranted.

The following list of claims appear to be related to accidental injury. In some cases more than one accident may have occurred. For each accidental injury represented, please provide the following:

1. A copy of the documentation used to determine if a third party was potentially liable for the injury that resulted.

2. If Subrogation/Right of Recovery follow-up was determined to be necessary and is ongoing, provide copies of all correspondence pertaining to your initial investigation and follow-up activity to date. Note: Copies of the telephone logs should be included.

3. If Subrogation/Right of Recovery follow-up was determined not to be necessary (ie there is no third party involvement), provide copies of all correspondence pertaining to your initial investigation that allowed that determination to be made.

4. If Subrogation/Right of Recovery reimbursement has been received, provide copies of refund checks, screen prints to support that claims history for this individual has been adjusted to reflect the refund, and documentation to support that the refunds have been credited to the client's claim account.

Administrator's Response

Please see subrogation investigation information attached.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Subrogation/Right of Recovery from Third Party

Substantive Testing Questionnaire

Questionnaire ID:	16
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for condition(s) for which investigation into the potential for Subrogation and/or the exercise of the Right of Recovery provision was warranted.

The following list of claims appear to be related to accidental injury. In some cases more than one accident may have occurred. For each accidental injury represented, please provide the following:

1. A copy of the documentation used to determine if a third party was potentially liable for the injury that resulted.

2. If Subrogation/Right of Recovery follow-up was determined to be necessary and is ongoing, provide copies of all correspondence pertaining to your initial investigation and follow-up activity to date. Note: Copies of the telephone logs should be included.

3. If Subrogation/Right of Recovery follow-up was determined not to be necessary (ie there is no third party involvement), provide copies of all correspondence pertaining to your initial investigation that allowed that determination to be made.

4. If Subrogation/Right of Recovery reimbursement has been received, provide copies of refund checks, screen prints to support that claims history for this individual has been adjusted to reflect the refund, and documentation to support that the refunds have been credited to the client's claim account.

Administrator's Response

Please see subrogation investigation information attached.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Workers Compensation

Substantive Testing Questionnaire

Questionnaire ID:	17
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for conditions that may be work related and the responsibility of the individual's workers' compensation plan. Please respond to the following:

1. Was an investigation conducted to determine if the condition on the claim(s) listed below was work related?

[ ] Yes - What were the results of the investigation?
[ ] No - Explain why no investigation was conducted.

2. If found to be a work-related condition, has recovery of payments made by this Plan been initiated?

[ ] Yes - What is the status of recovery? (i.e. how much has been recovered, when was the last follow up made)
[ ] No - Explain why recovery has not been initiated.

Administrator's Response

Please see subrogation/third party injury investigation attached. Care was not the result of a work related injury.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Workers Compensation

Substantive Testing Questionnaire

Questionnaire ID:	18
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for conditions that may be work related and the responsibility of the individual's workers' compensation plan. Please respond to the following:

1. Was an investigation conducted to determine if the condition on the claim(s) listed below was work related?

[ ] Yes - What were the results of the investigation?
[ ] No - Explain why no investigation was conducted.

2. If found to be a work-related condition, has recovery of payments made by this Plan been initiated?

[ ] Yes - What is the status of recovery? (i.e. how much has been recovered, when was the last follow up made)
[ ] No - Explain why recovery has not been initiated.

Administrator's Response

Please see subrogation/third party injury investigation attached. Care was not the result of a work related injury.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Denial of Mandated Benefits

Substantive Testing Questionnaire

Questionnaire ID:	19
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claims for conditions which are required to be covered under the Women's Health and Cancer Rights Act (effective in 1998), specifically reconstruction of the breast(s) following a mastectomy.

The claim(s) for the treatment in question are listed below. No payment was made for this claim(s). Please respond to the following:

1. Why was no payment issued for this claim(s)?

2. How are claims for breast reconstruction identified and investigated?

3. Provide documentation that supports the denial of this claim(s).

Administrator's Response

1) Claim was originally denied for failure to precert service 19370.

2) Services are identified by CPT code. Service code 19370 requires prior auth/Review for medical necessity. Services are approved during Review if deemed medically necessary, or due to a mastectomy.

3) Services were approved once supporting medical documentation was submitted and reviewed.

Conclusion

A procedural deficiency has been identified. This member had a mastectomy and breast reconstruction on 3/5/13; therefore it was already established that any related care would be medically necessary and should not have been denied for any reason, including precertification. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Large Claim Review

Substantive Testing Questionnaire

Questionnaire ID:	20
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred a material amount of claim payment on one claim (Claim No. 767133159231220000000 with a payment of $73,831.47; OACP)

1. Please provide copies of documentation of your high dollar claim review procedures.

2. Confirm that your high dollar claim review procedures were followed on this claim by providing the date the review was completed.

3. Was case management involved on this individual at the time of this claim? If not, was case management review triggered as a result of this large individual claim?

Administrator's Response

1) Please refer to the Questionnaire for overview of High Dollar process.

2) High Dollar Panel review completed. Processor ID CCPJXD has high dollar claim authority and released payment as a result of high dollar review.

3) Inpatient stay was authorized by inpatient Case Managers. Patient had also been identified for potential ongoing case management involvement. Case management reviewed care w/patient. No further impacts were identified and case closed.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Case Management

Substantive Testing Questionnaire

Questionnaire ID:	21
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for brain tumors that Case Management review and involvement was warranted.

Please provide copies of documentation of case management activity during the audit period shown above. This documentation should include all of the following:

1. Referrals from the claims administrator to Case Management, including the date of referral.

2. All case management notes. This should include notes documenting the acceptance or rejection of the referral, ongoing clinical information, referrals to other functions such as disease management or member services and contract or other reimbursement related negotiations.

3. If reimbursement related negotiations took place, documentation showing final terms agreed to.

4. Document any charges from case management for this case. Include all supporting information.

Administrator's Response

Patient was identified for oncology case management. Case was opened 1/4/13 and Case Manageemnt was actively engaged through 10/29/13, when patient passed away.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Case Management

Substantive Testing Questionnaire

Questionnaire ID:	22
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for multiple sclerosis (MS) that Case Management review and involvement was warranted.

Please provide copies of documentation of case management activity during the audit period shown above. This documentation should include all of the following:

1. Referrals from the claims administrator to Case Management, including the date of referral.

2. All case management notes. This should include notes documenting the acceptance or rejection of the referral, ongoing clinical information, referrals to other functions such as disease management or member services and contract or other reimbursement related negotiations.

3. If reimbursement related negotiations took place, documentation showing final terms agreed to.

4. Document any charges from case management for this case. Include all supporting information.

Administrator's Response

Primary treatment, injection J2323, requires review and have been approved based on information provided (see attached approval on file). No additional opportunities to add value through a formal case management service have surfaced for this patient. The occurrence of a specific diagnosis or procedure performed does not necessarily indicate that we can add value for the customer or the employer through case management services. We use the multiple sources of information at our disposal, such as claims data, lab data, Rx data, and recorded Cigna nurse's notes, to gain thorough understanding to the member's particular situation. Only cases where we have an opportunity to add further value to the patient via case management are slected for participation in the various programs.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Hemophilia/Blood Products

Substantive Testing Questionnaire

Questionnaire ID:	23
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred material amounts of claims payments for condition(s) for blood products for the condition of hemophilia.

Please provide copies of documentation of case management and/or discount negotiations for these expenses during the audit period shown above. This documentation should include all of the following to the extent it is available.

1. Referrals from the claims administrator to Case Management for review.

2. Copies of reports or Case Management notes of negotiated discounts or other savings on the blood products charges.

Administrator's Response

Primary treatmemt on record, injection J7192, requires review and have been approved based on information provided (see attached approval on file). Patient is also receiving service through Cigna's National Vendor. No additional opportunites to add value through a formal case management service have surfaced for this patient.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

In-Network Discounts vs. URC

Substantive Testing Questionnaire

Questionnaire ID:	24
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The claim data provided to CTI has been used to identify potentially overpaid claims. The above service was identified because the allowed amount for this procedure performed by a network provider was at least 25% greater than what the allowance would have been if the procedure had been considered under UCR for this zip code area. Please provide a copy or screen print of the scheduled allowance for this provider, procedure, and date of service.

Based on this documentation, please answer the following questions:

Was the service line paid in accordance with the contracted provider discount schedule?
[ ] Yes [ ] No

If No above, what should the allowance have been? $_____
Has the overpayment been recovered at this time?
What caused the claim to pay incorrectly?
If Yes above, explain why the negotiated rate would be higher than the UCR allowance for an in-network provider:

Administrator's Response

Please see attached. Claim was processed in accordance with pricing received - Allegiance TPV network (on claim).

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

PPO Provider and No Discount Taken

Substantive Testing Questionnaire

Questionnaire ID:	25
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for services from a provider participating in a network contracted with this Plan. However, no discount was taken on the claim according to the data provided to CTI. Please respond to the following:

1. Was the provider participating in the network at the time this claim was paid?

___ Yes - Explain why a discount was not taken on this claim.

___ No - Provide documentation such as screen prints that show the provider's participation status.

Administrator's Response

Please see bill attached. Claim was processed correctly in accordance with contract for Cigna's National Ancillary vendor. Fee Schedule CIGNA9AB - Provider bills with contracted rate, no additional discount applied.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Non-PPO Provider with Incorrect Copayment

Substantive Testing Questionnaire

Questionnaire ID:	26
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having received claim payments for services from a non-network provider. However, a copayment was taken on the claim according to the data provided to CTI. Please respond to the following:

1. Was the provider participating in the network at the time this claim was paid?

___ No - Explain why a copayment was taken on this claim.

___ Yes - Provide documentation such as screen prints that show the provider's participation status.

Administrator's Response

Services rendered by an out-of-network physician. As an emergency room physician service, claim is payable at the in-network benefit level with the copayment applied.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Multiple Surgical Procedures Should be Reduced Fee

Substantive Testing Questionnaire

Questionnaire ID:	27
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as having incurred claim(s) for multiple surgical procedures during the same operative session. The allowable amount was not calculated following standard multiple surgical guidelines. Please provide the following information regarding this claim payment and attach it to this form:

1. Explain how the allowable amount was calculated for the below referenced claim.

2. Explain the standard method used to calculate the allowable for multiple surgical procedures performed during the same operative session.

Administrator's Response

1) Claim was processed in accordance to pricing received - Allegiance TPV Network.

2) Multiple surgery reduction was not applied to services 33508 and 33518, as codes are exempt from multiple surgery reduction and 100% of the allowable applies (see attached).

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Payments for Over Age Dependents

Substantive Testing Questionnaire

Questionnaire ID:	28
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 - 12/31/2013

The above referenced individual was identified by ESAS® as being a dependent over the limiting age. The plan states that in order to remain a covered dependent over the limiting age, the dependent must be an unmarried full-time student or handicapped. Please provide the following:

1. A copy of the documentation received during the audit period that verified that this dependent continued to be eligible for coverage under the plan after reaching the limiting age. (i.e. unmarried full-time student status, verification of handicapped status)

2. A copy or a written explanation of your administrative protocols for updating verification of unmarried full-time student status and handicapped child status.

Administrator's Response

Dependent eligibility is maintained by the State of Montana and/or their eligibility vendor. Claim was adjudicated in accordance with eligibility information on file at time of processing.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

NCCI Medically Unlikely Edits (MUEs)
Substantive Testing Questionnaire

Questionnaire ID:	29
Client:	Montana State CIGNA
Audit Period:	01/01/2013 – 12/31/2013

The above referenced individual was identified by ESAS® as having potential overpaid claim payment(s) according to The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiatives (NCCI) Medically Unlikely Edits (MUEs).

The claim listed below appears to contain improper coding conventions as defined by NCCI edits. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing the maximum number of daily service units from being exceeded.
2. A copy of each bill.
3. If the listed claim is improperly coded, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Claim was properly adjudicated in accordance with Cigna's reimbursement procedures, in accordance with Cigna's ClaimCheck logic which incorporated McKesson frequency edits, the allowance for code 88331 was permitted and was not limited to 11 units. While CMS edits are considered in establishment of Cigna's reimbursement procedures, not all edits may be used. At the time of processing Cigna's reimbursement policies did not include CMS MUE edits.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

NCCI Procedure-to-Procedure Edits
Substantive Testing Questionnaire

Questionnaire ID:	30
Client:	Montana State - CIGNA
Audit Period:	01/01/2013 – 12/31/2013

The above referenced individual was identified by ESAS® as having potential overpaid claim payment(s) according to The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiatives (NCCI) Procedure-to-Procedure Edits.

The claim listed below appears to contain improper coding conventions as defined by NCCI edits. For each claim, please provide the following:

1. A copy of your administrative procedures used in identifying and preventing improper coding conventions.

2. A copy of each bill.

3. If the listed claim is improperly coded, provide documentation that the overpayment has been refunded and credited to the client's account.

Administrator's Response

Claim was properly adjudicated in accordance with Cigna's reimbursement procedures, in accordance with Cigna's ClaimCheck logic. Please see attached reflecting approval of serices with Modifiers billed.

Conclusion

No procedural deficiency has been identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

No payment error was identified. Any other claim like this one flagged by ESAS can only be considered to be processed correctly when paid at the direction of the State of Montana.

Exhibit B.

Cigna Final Response to Working Draft Report

Cigna
Response

Claim Administration Audit
Draft Report

For

State of Montana

April 2014

Executive Summary

Cigna would like to thank both Claim Technologies Incorporated (CTI) and the State of Montana for the opportunity to respond to the audit report received from CTI. CTI conducted an audit of medical claims processed by Cigna on behalf of the State of Montana at Cigna's Bourbonnais, IL service center during the week of March 17, 2014. The onsite review consisted of a statistical sample of 180 medical claims processed during the period of January 1, 2013 through December 31, 2013. CTI's audit also included an electronic screening analysis (ESAS) of claims processed during the scope period, along with a subsequent audit of 30 focused test claims from this review while onsite.

Specifically, the audit identified the following:

Statistical Sample

- 3 underpayments totaling $420.78
- 1 overpayment in the amount of $2,858.20

Cigna confirms 1 underpayment error in the amount of $360.00 from the statistical sample. Cigna's comments on each of the specific audit samples are provided in the Field Audit Summary section below. Any agreed upon underpayments were corrected with additional payments made after the onsite review.

Cigna Response to Field Audit Summary (pages 3-12):

CTI Reported Results

	Sample Results	Weighted Results
Documentation Accuracy – Financial	100%	100%
Documentation Accuracy – Frequency	100%	
Financial Accuracy	98.84%	96.91%
Accurate Payment Frequency	97.78%	
Adjudication Proficiency	99.58%	
Accurate Processing Frequency	97.78%	
Claim Turnaround- Median Average Turnaround Time for the sample	11 days	

The financial accuracy results reported by CTI were heavily influenced by a single overpayment in the amount of $360.00 associated with sample 1090. We observed the sample incorporated only $284,742.12 in paid claim amounts out of the total amount issued of $89,413,284 during the scope period. This represents less that .01% of the total dollars issued. Cigna observed the random sample did not include any claims with payments in excess of $45,224.00 and claims with payments less than $500.00 accounted for 65% of the sample. With an industry standard auditing methodology utilizing paid amounts for the stratification process rather than charge amounts, we would expect to see a larger percentage of paid dollars and/or more representation of higher dollar paid claims selected for review.

Cigna is pleased, however, that the results of this review reflect that minimal payment errors were observed. The three additional errors assessed by CTI were previously identified by Cigna and corrected during the scope period of the audit and were correct at the time of the onsite review. With the payment accurately made for the claims within the scope period, there are no additional financial impacts to the State of Montana. We find this error assessment methodology differs from the industry norm, as consistent with industry standards, if a claim has been corrected (adjusted or refunded) within the scope of the audit, the claim would be considered processed correctly or would be classified as a procedural error only as the appropriate dollar levels have been issued (or refunded).

With the minimal amount of errors observed in this review, we do not believe the weighted results of this review are indicative of Cigna's overall service performance on behalf of the State of Montana. Documentation Accuracy (Financial and Frequency) and Adjudication Proficiency are not standard measures currently utilized by Cigna when undergoing audit reviews.

In comparison, Cigna continued to meet the quarterly Performance Guarantee targets in 2013. For the State of Montana, the accuracy results are based upon a random stratified sampling 250 claim per quarter from all claims processed by the primary claim office aligned with the account during the audit period. The Cigna service team has achieved the following accuracy results throughout the same audit scope period.

CLAIM PAYMENT ACCURACY	
	Payment Accuracy
1st Qtr 2013	99.8%
2nd Qtr 2013	99.7%
3rd Qtr 2013	98.2%
4th Qtr 2013	99.5%
Full Year 2013	99.3%
Standard	98%

Cigna continues to look for ways to improve the accuracy and efficiency of claim and call handling allowing us to provide consistently high levels of service to the State of Montana and their employees. Cigna has addressed each of the agreed to errors with the individual processors, so they are educated on the correct processing going forward. The Cigna Claim Managers also meet regularly with the State of Montana processing team to provide any applicable updates or education. Cigna looks forward to meeting with the State of Montana to discuss the results of this review and share the action plan which has been developed to address the errors observed by CTI.

While CTI's findings were favorable regarding claim turn around time (TTP), Cigna does not calculate claim TTP in the same fashion. Claim turn around time information is shared by Cigna with State of Montana quarterly.

Financial, Payment and Processing Accuracy Results

Cigna confirmed one of the four financial errors assessed by CTI. Cigna respectfully disagrees with the assessment of the financial errors on samples 1015, 1039 and 1086. Correct payments for these claims were made within the audit scope period. Comments on the specific audit samples are provided below.

Sample 1015 and 1039

Cigna confirms that underpayments totaling $60.78 occurred during the initial processing of the sample claims as a result of incorrect entry of Medicare's payment information during processing. To properly calculate Cigna's standard liability to determine the benefits payable as secondary carrier, the claim processors must ensure the Medicare payment information is entered at the service line level vs. the claim level. Individual coaching and feedback have been provided to the claim processors. Both underpayment situations were identified by Cigna and corrected within the scope of the audit, prior to the onsite review. The additional payment of $4.26 for sample 1015 was issued on November 12, 2013. The additional payment of $56.52 for sample 1039 was issued on May 20, 2013. There are no additional financial impacts to the State of Montana on these claims at this time.

Sample 1086

Cigna confirms that an overpayment in the amount of $2,858.20 occurred during the initial processing of sample claim 1086 as a result of an incorrect calculation by the claim processor. However, the overpayment had already been identified by Cigna and a request for the refund was generated on July 25, 2013. The refund was received and posted to the claim record and credited to the State of Montana on October 29, 2013, prior to the onsite review. There is no additional financial impact to the State of Montana on this claim at this time. Individual coaching and feedback have been provided to the claim processor.

Sample 1090

Cigna confirms an underpayment in the amount of $360.00 as assessed by CTI for the sample claim. The claim processor incorrectly denied an eligible service. Individual coaching and feedback have been provided to the claim processor. The claim was sent for correction and issuance of additional payment at the conclusion of the audit.

Field Audit - Additional Observations (page 13-14)

Cigna has reviewed the additional observations noted by CTI in connection with the random review. The majority of the observations provide confirmation of corrective actions Cigna completed during the scope period in accordance with various benefit clarification initiatives performed in partnership with the State of Montana to ensure claims are being adjudicated accurately per the State's intent. Additional commentary on several of the specific audit samples is provided below.

- Samples 1002, 1067, 1080, 1087, 1103, 1106 and 1140 – On behalf of the State of Montana, throughout 2013, Cigna partnered closely with the Allegiance network to improve the overall repricing process for the State's claims. In March 2013

Cigna instituted a process to obtain pricing from Allegiance when pricing was not included on the claim submission received from the contracted Health Care Professional. The majority of the claims associated with CTI's observations were initially processed during the first quarter 2013.

- Sample 1068 – The sample claim was processed in accordance with the contract pricing information received from Allegiance. In the case of the specific Health Care Professional, Cigna has received direction that no further multiple surgical reductions should be applied during processing in accordance with the Health Care Professional's contract.
- Sample 1149 – The initial processing of the sample claim, as well as the out-of-sample claims observed by CTI, was correct based on the eligibility information presented to Cigna at the time of payment. The termination date for the customer was retroactively provided to Cigna after the claims were processed. Cigna would be happy to review timely submission guidelines for eligibility termination with the State of Montana to identify areas of improvement as warranted. Cigna understands that even a short time span of retroactive terminations can create an overpayment situation. Any opportunity to shorten the eligibility notification processes will only help reduce the impacts to claim payments. Cigna identified the overpayments as a result of the updated termination date received and recovery efforts were initiated. Overpayment recovery efforts remain active at this time.
- Sample 1155 – The State of Montana has elected the Standard COB without Benefit Credit coordination provision. During the onsite review, Cigna provided the auditor with a copy of our Standard Operating Procedure (SOP) outlining the calculation of allowances for plans with Standard COB. In accordance with our SOP, the allowance is based on the greatest/higher amount allowed between the Primary carrier's Maximum Reimbursable Charge (MRC)/negotiated rate **OR** Cigna's or Allegiance's MRC/negotiated rate. Cigna will pay the lesser of our original liability and the coordination amount. For Cigna or Allegiance contracted health care professionals (HCP), we are bound by the terms of the contract between with our HCP and are obligated to honor the rates under the contract. The claim was correctly adjudicated in accordance with State of Montana's COB election; the health care professional's contracted rates and Cigna's standard operating procedures. Cigna would be happy to further review the COB provision election with the State of Montana to ensure the election in place meets their intent.
- Sample 1158 – A refund was received for the sample claim submission. Upon receipt, the refund was applied to the claim record, which credited the payment back to the State of Montana. When refunds are received, for a claim with deductible applied, Cigna's Standard Operating Procedures do not include determining other claims paid in history which could now be subject to deductible as a result of the refund being received, which reduced the amount accumulated towards the patient's annual deductible maximum. In our experience, the deductible will often be re-satisfied on new claim submissions as the deductible maximum will no longer reflect having been satisfied. Cigna would be happy to discuss the refund application process with the State of Montana.

Cigna would be happy to discuss the additional observation topic with the State of Montana if they have any questions.

Cigna Response to ESAS Summary (pages 1-16):

In order to fully audit a claim for payment accuracy, we maintain that an on-site audit is required to review the hard copy sample claim against our claim processing system, internal procedures and provider contract information. Cigna's claim payment system contains payment details that cannot be captured in an electronic file. As a result Cigna does not support electronic analysis reviews. However, as CTI agrees to perform an onsite review for a selection of claims identified from their electronic analysis; we have continued to partner with CTI on the review of the targeted selections onsite. Cigna is pleased with CTI's finding that there were no procedural deficiencies observed for all but one of the thirty ESAS targeted claim selections reviewed. We continue to look for ways to improve the accuracy and efficiency of claim and call handling allowing us to provide consistently high levels of service to the State of Montana and their employees.

I. **Duplicates**

Cigna is pleased no duplicate payment deficiencies were observed during the onsite review. Cigna has in place a thorough duplicate claim review process. Cigna's claim systems have built in logic within the system which provides a flag to the processor when a potentially duplicate claim is presented for processing. The most frequently identified are "Exact" duplicates or "Possible" duplicates. The system will compare the provider name, date of service, type of service and charges to flag for duplicate services. These edits alert Claim Processors that duplicate services may have been received and further investigation is necessary.

In Addition to our claim system edits, Cigna's National Overpayment Identification Team (NOIT) receives and reviews Cigna's paid claim data each week, using proprietary queries and edits, to identify potential overpayments. Cigna also partners with several specialized vendors to identify and collect overpayments not identified within our baseline programs.

Between our pre-payment edits, and post-payment review processes, Cigna has established controls to minimize duplicate payments and capture incorrect payments issued.

II. **Denial of Mandated Benefits**

Cigna provides coverage for Breast Reconstruction services following a mastectomy in accordance with the Women's Health and Cancer Rights Acts. Breast Reconstruction procedures are on Cigna's list of services requiring pre-authorization or medical necessity review, as the services can be performed for reasons other than post-mastectomy care. Cigna maintains a listing of services requiring pre-certification and/or medical review, making updates as warranted. The information is published on our website for reference by health care professionals.

In the ESAS sample reviewed, sample 19, pre-authorization was not obtained resulting in the denial of the claim as not being pre-authorized. The claim was processed in accordance with Cigna standard operating procedures. In this situation, medical records may be provided to support the medical necessity for the procedure and the claim may be reprocessed and allowed upon review. Cigna stands by the initial denial of the claim based on lack of the necessary pre-authorization. Upon receipt of additional supporting documentation and completion of medical review, the service was authorized and processed accordingly on January 15, 2014. During the review process, if medical records support that the reconstruction performed is the result of cancer surgery, the services would be approved and processed, which would be in compliance with the Women's Health and Cancer Rights Act.

Cigna Response to Operational Review

In conjunction with the audit project, Cigna was asked to complete an Operational Review Questionnaire prior to the onsite audit. The Operational Review report presents CTI's general observations and recommendations based on their analysis of the material. Cigna would be happy to discuss any questions State of Montana may have as a result of the operational review and the findings or recommendations noted by CTI.

RANDOM SAMPLE AUDIT REPORT

The State of Montana Medical Plan
Administered by:
Cigna
Audit Period: January 1, 2013 – December 31, 2013

Prepared: April 25, 2014

Private and Confidential

RANDOM SAMPLE AUDIT REPORT
Table of Contents

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Overview

Random Sample Audit Objectives

The objectives of the Random Sample Audit are to verify that claims are being paid in accordance with plan specifications and the administrative agreement, to measure administrative process quality versus established indicators, and to identify administrative process deficiencies for remediation or further review.

Random Sample Audit Scope

The scope of our random sample audit included an on-site review of Cigna's claims processing facility in Bourbonnais, IL and a stratified random sample of 180 paid or denied claims for employees and dependents with coverage under the State of Montana medical plans. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. Each claim in the sample was reviewed by a CTI auditor to ensure that it conformed to the plan specifications, agreements, and negotiated discounts.

Performance was measured for seven Key Performance Indicators as follows:

- Documentation Accuracy – Financial
- Documentation Accuracy – Frequency
- Financial Accuracy
- Accurate Payment Frequency
- Adjudication Proficiency
- Accurate Processing Frequency
- Claim Turnaround

Also reported are Additional Observations regarding processes or payments beyond the scope of the Random Sample Audit. Other reported categories include Coordination of Benefits (COB) Savings, Records Retrieval and Data Coding Validity. Definitions of the Key Performance Indicators are provided later in this section along with their respective reported results.

Random Sample Audit Methodology

Each sampled claim selected for the Random Sample Audit was reviewed by a CTI auditor for conformance to the plan specifications, agreements, and negotiated discounts.

Errors were cited when a claim selected in the random sample was paid or processed incorrectly based on member eligibility or plan provisions as defined in the Summary Plan Description or amendments to it. Payment errors were observed based on the way the selected claim was paid and the information the administrator had at the time that transaction was processed; if the claim was later corrected, the error still is cited so

that focus can be placed on how to reduce errors and re-work of claims. Additional observations (not errors) were cited when processes or payments beyond the scope of the sample were observed. CTI's audit system categorizes errors into one or more of six Key Performance Indicators.

The discussion between CTI and Cigna of any error or additional observation made by CTI's team during the onsite review was recorded in CTI's audit system. A preliminary Random Sample Audit report was reviewed and responded to by Cigna and their written response was taken into consideration before producing this final report. Ultimately payment and procedural errors that remain after the written dialogue between the Claims Administrator and CTI is completed are accumulated and used to arrive at the level of performance accuracy for each Key Performance Indicators. We then review the preliminary Random Sample Audit results with the Claim Administrator before producing final reports and recommendations for the Plan Sponsor.

The process and impact of improving processes and adjusting payment errors identified through this Random Sample Audit (and in conjunction with the Operational Review and Electronic Screening and Analysis) should be discussed by the Plan Sponsor and the Claim Administrator. CTI stands ready to assist the Plan Sponsor in discussions of the Random Sample Audit results to whatever extent requested.

Random Sample Audit Findings by Key Performance Indicator

Performance, as measured by the Random Sample Audit sample for each Key Performance Indicator, is presented in the pages immediately following.

Documentation Accuracy - Financial

Operational Definition: ***<u>The dollar amounts processed with documentation adequate to substantiate payment or denial</u>*** ***compared to <u>the dollar amounts processed in the Audit Sample.</u>***

The Audit Sample revealed documentation to support all payments was present.

Documentation Accuracy - Financial for the claims sampled is 100%.

On a weighted, adjusted basis for the audit universe Documentation Accuracy - Financial is 100%.

Documentation Accuracy - Frequency

Operational Definition: ***<u>The number of claims processed with documentation adequate to substantiate payment or denial</u>*** ***compared to <u>the total number of claims processed in the Audit Sample.</u>***

The Audit Sample revealed there were no inadequately documented payments.

Documentation Accuracy -- Frequency for the audit sample is 100%.

Financial Accuracy

Operational Definition: ***<u>The total correct claim payments that were made</u> compared to <u>the total dollars of correct claim payments that should have been made</u> for the Audit Sample. The formula for this measure is: Total correct payments (claims paid in the sample minus overpayments plus underpayments) minus the absolute variance (overpayments plus underpayments), divided by total correct payments.***

Claims sampled and reviewed by CTI revealed $420.78 in underpayments and $2,858.20 in overpayments, for a combined variance of $3,278.98. The correct payment total for the 180 claims in the audit sample should have been $282,304.70.

Financial Accuracy for the claims sampled is 98.84%.

On a weighted, adjusted basis for the audit universe Financial Accuracy is 96.91%.

Each error found in the Random Sample Audit is listed in the following Error Detail Report titled “Financial Accuracy and Accurate Payment Frequency.”

CTI Error Detail Report
Financial Accuracy and Accurate Payment Frequency

Client: Montana State - CIGNA
Audit 1/1/2013 - 12/31/2013
Audit Numbers: 1001 - 1180

Run Date: 4/22/2014

Primary Cause	Indicator Description	CTI AuditNo.	Claim No.	Entered Amount	Correct Amount	Under Paid	Over Paid
FL	Frequency limits not applied						
		1090	822133399017520131217	$0.00	$360.00	($360.00)	$0.00
	Subtotal: 1			$0.00	$360.00	($360.00)	$0.00
MCI	Incorrect COB with Medicare						
		1015	867130789973320130403	$1,179.74	$1,184.00	($4.26)	$0.00
		1039	467130459030220130215	$1,127.48	$1,184.00	($56.52)	$0.00
	Subtotal: 2			$2,307.22	$2,368.00	($60.78)	$0.00
OIPO	Other insurance payment overlooked						
		1086	467131359025620130523	$4,317.77	$1,459.57	$0.00	$2,858.20
	Subtotal: 1			$4,317.77	$1,459.57	$0.00	$2,858.20
Total Number of Claims: 4						($420.78)	$2,858.20

Accurate Payment Frequency

Operational Definition: Accurate Payment Frequency compares the number of bills paid correctly to the total number of bills paid for the Audit Sample.

The Audit Sample revealed 4 incorrectly paid bills and 176 correctly paid bills. The incorrectly paid bills were comprised of 3 underpaid bills and 1 overpaid bills.

Accurate Payment Frequency for the claims sampled is 97.78%.

Each error found in the Random Sample Audit is listed in the Error Detail Report shown in the preceding Error Detail Report titled “Financial Accuracy and Accurate Payment Frequency.”

Adjudication Proficiency

Operational Definition: ***<u>The number of correct adjudication decisions made</u> compared to <u>the total number of adjudication decisions required</u> for the bills in the Audit Sample.***

946 separate decisions were reviewed during the audit. An average of 5.3 decisions for each bill was reviewed to determine Adjudication Proficiency. Four adjudication errors were observed in the Audit Sample.

Adjudication Proficiency for the claims sampled and all claims in the universe is 99.58%.

The adjudication errors found in the Random Sample Audit are shown in the following "Adjudication Proficiency" Error Detail Report. Adjudication errors can result in payment errors and/or may have been the result of inadequate documentation. To the extent that this has occurred, the same CTI Audit Numbers may appear on both the following Error Detail Report titled "Adjudication Proficiency" as well as that preceding entitled "Financial Accuracy and Documentation Accuracy – Financial."

CTI Error Detail Report
Adjudication Proficiency

Client: Montana State - CIGNA
Audit 1/1/2013 - 12/31/2013
Audit Numbers:1001 - 1180

Run Date: 4/22/2014

Error Type	Question Description	Indicator	Indicator Description	Examiner Flag	CTI Audit	LineNo.	Provider ID
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1015		
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1039		
ADJUD	COB Adjud	OIPO	Other insurance payment overlooked		1086		
	3 COB Adjud						
ADJUD	Policy Provisions	FL	Frequency limits not applied		1090	003	
	1 Policy Provisions						

Examiner Error:	4
System Error:	0
Total Count:	4

Accurate Processing Frequency

Operational Definition: The number of bills processed without errors compared to the total number of bills processed in the Audit Sample.

When a bill has errors found in more than one category, it is counted only once as a single incorrect bill for this measure.

The Audit Sample revealed 176 bills processed without any type of error, while 4 bills had one or more errors.

Accurate Processing Frequency for the sample and all claims in the universe is 97.78%.

There is no Error Detail Report for this performance indicator since the specific errors are referenced in respect to other measures in this report.

Claim Turnaround

Operational Definition: The <u>number of calendar days required to process a claim</u> -- from the date the claim is received by the administrator to the date a payment, denial, or additional information request is processed -- expressed as both the Mean Average and Median for the Audit Sample.

Median Claim Turnaround Time for the claims sampled was 11 days from *Date Received by the Claim Administrator* to *Date Claim Processed*. Same day turnaround on claims is the fastest turnaround time that can be achieved, but is not necessarily the best turnaround time. The claim administrator should balance claim turnaround by handling all types of claims as efficiently as possible.

A detailed Claim Turnaround Analysis is presented in the following report titled “Claim Turnaround Analysis.”

NOTE: Claim administrators commonly measure Claim Turnaround Time in Mean Average Days. Median Days, however, is a more meaningful measure for the administrator to focus on when analyzing Claim Turnaround because it prevents one or a few claims with extended Turnaround Time(s) from distorting the true performance picture. The Mean Average Claim Turnaround from *Date Received* to *Date Processed* was 13 days.

CTI Claim Turnaround Analysis
Paid and Pended

Client: Montana State - CIGNA
Audit Period: 1/1/2013 - 12/31/2013
Audit Numbers: 1001 - 1180

Average Claim Turnaround based on Number of Days between Received and Processed Dates: 13 days

Number of Days Between Received and Processed Dates:

1 Day	0	26 Days	0
2 Days	26	27 Days	0
3 Days	5	28 Days	3
4 Days	4	29 Days	1
5 Days	4	30 Days	1
6 Days	6	31 Days	0
7 Days	4	32 Days	1
8 Days	6	33 Days	0
9 Days	15	34 Days	1
10 Days	11	35 Days	1
11 Days	9	36 Days	1
12 Days	9	37 Days	0
13 Days	12	38 Days	0
14 Days	15	39 Days	0
15 Days	11	40 Days	0
16 Days	7	41 Days	0
17 Days	6	42 Days	0
18 Days	4	43 Days	0
19 Days	2	44 Days	0
20 Days	2	45 Days	1
21 Days	3	> 45 Days	5
22 Days	1	Undetermined:	0
23 Days	2	Total Number of Claims:	180
24 Days	1		
25 Days	0		

Median: 11 Days

Additional Observations and Results

During the course the of audit, procedures or situations may be observed which may not have caused an error on the sampled claim, but which may have impact on future claims or the overall quality of service.

ADDITIONAL OBSERVATIONS	CTI AUDIT #
Repricing transmission discrepancies from the Allegiance network requiring reprocessing of claims – per Cigna Benefits Clarification listing.	1002, 1067, 1080, 1087, 1103, 1106, 1140
Benefits for the first colonoscopy regardless of diagnosis (preventive or diagnostic) is to be covered at 100%, all subsequent services paid at place of service bounds – per Cigna Benefits Clarification listing.	1040, 1085
Cigna updated the Allergy and Injections benefit in an office setting to process at coinsurance, plan deductible waived – per Cigna Benefits Clarification listing.	1028, 1063
Cigna completed an accumulator rebuild for the Classic Plan due to identifying cross-accumulation not in place. This created adjustments for claims over maximum – per Cigna Benefits Clarification listing.	1137
Claims from Sleep Diagnostics were to be processed and allowed without requirement for authorization (gold card status) – per Cigna Benefits Clarification listing.	1150
Cigna updated their claim system to apply a $100 copay to ER Physician for the Choice Plan and $250 for ER facility claims, waiving deductible per clarification from the State. A reprocessing was submitted to adjust claims – per Cigna Benefits Clarification listing.	1114
Cigna does not apply multiple surgery reductions to serveral facilites because these providers apply the reduction prior to submitting the claim. There is no indication that this provider has applied a multiple procedure reduction on this claim. The State of Montana should discuss with Cigna how to verify that these providers are applying multiple procedure reductions.	1068
For this member, CTI notes any claims incurred after the retro-termination date, but processed prior to receiving the retro-termination date, are in the refund recovery process. The State of Montana should be provided the status of recovery efforts on this member, plus any other recovery efforts that are ongoing.	1149

Processing claims using COB type "Standard without Benefit Credit", as in the case of the sample claim, can cause the State of Montana plan to issue secondary plan benefits in excess of the patient responsibility following the primary plan's payment. It is noted that the provider requested a refund request be made because they were paid in excess of the primary plan's patient responsibility. CTI recommends the State review the plan's COB methodology to ensure that payment made as a secondary plan does not exceed patient responsibility following a primary plan payment.	1155
When a refund is received and applied on a claim that took all or part of the deductible, claims history is not reviewed to determine if it should have applied to other claims. In this case, the member's $500 PPO deductible was adjusted out due to a refund received and, in effect, was no longer satisfied. The potential exists for benefits to be issued without satisfaction of meeting the deductible during the benefit year.	1158

ADDITIONAL AUDIT RESULTS	
COB Savings (weighted)	24.17%*
% of Claims Selected for Audit Sample for Which Complete Records Were Produced	100%**
Data Coding Validity	100%***

*Coordination of Benefits (COB) Savings was calculated based on the audit sample using the claim dollars saved by the plan through coordination with other group plans and Medicare as a percentage of the correct total claim dollars paid. The Random Sample Audit further indicated that COB Savings, if all claims had been coordinated correctly, would have been 24.42% of paid claims.

**180 claims initially were requested for the Audit Sample. Cigna provided documentation of 100% of the claims requested.

***A total of 2,542 data elements were verified in the audit. The sample revealed one coding or data entry errors.

Exhibits

A. Random Sample Audit Sample Construction and Weighting

B. Random Sample Audit Observation/Response Forms

C. Cigna Audit Response

Exhibit A.

Random Sample Audit Sample Construction and Weighting

Sample Construction and Weighting Methodology

Client: State of Montana

Audit Period: January 1, 2013 – December 31, 2013

Claim Universe (as converted)

Stratum	Claim Count	Total Charge Amount	Total Paid Amount
1	283,660	$39,306,619	$29,232,495
2	42,130	$56,753,666	$21,757,202
3	6,026	$107,554,245	$38,423,587
Totals	331,816	$203,614,529	$89,413,284

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	283,660	85.49%	60
2	42,130	12.70%	60
3	6,026	1.81%	60
Totals	331,816	100.00%	180

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	180	$284,742.12
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	180	$284,742.12
Audit sample if all claims paid correctly	180	$282,304.70
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$282,304.70

Exhibit B.

Random Sample Audit Observation/Response Forms

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:24 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130399808920130220
Audit No: 1002
Employee Relation: E
Auditor: John Spalten
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. An incorrect discount was applied on this claim. The claim initially paid $2,345.41. The claim should have paid $17,048.44. CTI will cite an adjudication error and a $14,703.03 underpayment. CTI notes that this claim was adjusted on 3/15/2013.

RESPONSE 1

A. Claim was processed correctly based on claim level repricing information passed to Cigna by Allegiance. After processing, a transmission issued on the Allegiance file was identified. Once identified, a reprocessing project was initiated to reprocess claims based on the line level repricing information from Allegiance. Claim is paid correctly within scope based on pricing provided by Allegiance.

CONCLUSION

A. Additional Observation Only: This claim was initially processed based on the claim level repricing information on the claim. It was subsequently determined that the claim level repricing information was incorrect and that Cigna should apply the line level repricing information. A repricing project was initiated by Cigna to correct all claims to reflect line level repricing.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130789973320130403
Audit No: 1015
Employee Relation: E
Auditor: John Spalten
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. Medicare patient liability was $1184. Claim paid only $1179.74. CTI will cite an adjudication error and $4.26 underpayment. CTI notes that this claim was adjusted on 11/21/13.

RESPONSE 1

A. Disagree. Claim is processed correctly within the scope period. Cigna identified additional payment was warranted based on initial processing and made necessary adjustments. Payment has been issued in full as of 11/21/2013.

CONCLUSION

A. CTI will continue to cite an adjudication error and $4.26 underpayment. The initial processing of this claim was incorrect.

FOR CTI INTERNAL USE ONLY ☑ FinAccum IDOC Primary
MCI FinPrimary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
FUP	001	($4.26)		☑	FINANCE	Financial
MCI				☑	ADJUD	COB Adjud
CER					INFO	COB Information
		($4.26)				

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 467132479200820130905
Audit No: 1028
Employee Relation: D
Auditor: John Spalten
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. IMMUNOTHERAPY INJECTIONS are subject to deductible. This member's deductible was not met. CTI will cite an adjudication error and $10.52 overpayment.

RESPONSE 1

A. As established during the implementation discussions with the State of Montana, the 2013 benefit plan's coverage for allergy injections initially reflected services were subject to plan deductible. After the claim was processed, Cigna received direction from the State of Montana that they wished to alter the benefit, waiving deductibles for allergy injections. Cigna's internal plan documents were updated accordingly and transmitted to Cigan internal partners on 8/3/13. The claim, processed on 9/5/13, was adjudicated correctly in accordance with the revised benefit.

OBSERVATION 2 **TO:**

A. Additional Observation Only: At the direction of the State of Montana, Cigna changed the processing of allergy injections to no longer be subject to the deductible. Allergy injection claims are paid at coinsurance only. This change was made on 8/3/13.

B. Additional Observation Only: CTI notes that an Allergy Injection claim for 1/11/13 was paid subject to coinsurance only. An Allergy Injection claim for 1/28/13 was applied to the deductible. Both claims processed on 2/7/13. Please explain why these 2 claims processed differently on the same day.

RESPONSE 2

A. and B. Agree. Based on information on file at the time, it would appear deductible should have been applied to the 1-11-13 date of service. The 1-28-13 was processed correctly. Tina F 4-3-14

CONCLUSION

A. and B. No errors, however, CTI cites an additional observation to note the processing of the sample claim falls under the updated Allergy and Injections benefit where an office setting processes at coinsurance, plan deductible waived. It is further noted that service date 1-11-13, an out of sample claim, was processed without being applied to the deductible, causing an $11.52 overpayment.

FOR CTI INTERNAL USE ONLY

☑ FinAccum IDOC Primary
FinPrimary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CSBU					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 467130459030220130215
Audit No: 1039
Employee Relation: S
Auditor: John Spalten
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. Medicare patient liability was $1184. Claim paid only $1127.48. CTI will cite an adjudication error and $56.52 underpayment. CTI notes that this claim was adjusted on 5/20/13.

RESPONSE 1

A. Disagree. Claim is processed correctly within the scope period. Cigna identified additional payment was warranted based on initial processing and made necessary adjustments. Payment has been issued in full as of 5/20/2013.

CONCLUSION

A. CTI will continue to cite an adjudication error and $56.52 underpayment. The initial processing of this claim was incorrect.

FOR CTI INTERNAL USE ONLY ☑ FinAccum IDOC Primary
MCI FinPrimary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
FUP	001	($56.52)		☑	FINANCE	Financial
MCI				☑	ADJUD	COB Adjud
CS					INFO	COB Information
		($56.52)				

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 967132209660820130827
Audit No: 1040
Employee Relation: S
Auditor: John Spalten
Conclusion Date: 03/27/2014

OBSERVATION 1 **TO:**

A. Medicare patient liability was $950.88. Claim paid only $856.97. CTI will cite an adjudication error and $93.91 underpayment. CTI notes that this claim was adjusted on 10/4/13.

RESPONSE 1

A. Disagree, the claim was billed with a non-preventive diagnosis and was first processed applying a deductible and coinsurance. The colonoscopy benefit changed to not apply the deductible and coinsurance to the member's first colonoscopy of the year, regardless of diagnosis. Benefits and claim was updated within the scope to indicate the claim was covered at 100%.

CONCLUSION

A. No errors. CTI makes an additional observation that this colonoscopy claim was adjusted to pay correct benefits within the audit period based upon benefit clarifications that "benefits for the first colonoscopy regardless of diagnosis (preventive or diagnostic) is to be covered at 100%, all subsequent services paid at place of service bounds".

FOR CTI INTERNAL USE ONLY

☑ FinAccum
FinPrimary
IDOC Primary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 967131279748820130511
Audit No: 1063
Employee Relation: E
Auditor: John Spalten
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. At the direction of the State of Montana, Cigna changed the processing of allergy injections to no longer be subject to the deductible. Allergy injection claims are paid at coinsurance only. This change was made on 8/3/13.

B. Additional Observation Only: CTI notes the following:
DOS 1/7/13 & 1/18/13 applied a discount of $17.10 and applied $15.83 to Ded

DOS 1/10/13, 1/15/13, 1/22/13, 1/28/13, 1/31/13, & 2/4/13 did not apply a discount, applied a $15 Copay, and paid $17.93.

DOS 2/13/13 & 2/25/13 applied a discount of $17.10, applied a $15 Copay, and paid $.83.

For these dates of service, the deductible was not met.

Please explain why these claims were processed differently.

RESPONSE 1

Clarification: the response regarding allergy injections for sample 28 pertained only to the plan intent confirmation on the OACI benefit plan. Sample claim 63 is for the OACP benefit plan.

A. Disagree. This customer is on the OACP benefit plan. Cigna initially reflected the 2013 OACP benefit plan's coverage for allergy injections were subject to the plan copayment in-network. Clarification of the benefit was made with the State of Montana confirming that in-network allergy injection services should have deductible and copayments waived, applying only the plan coinsurance. Cigna's internal plan documents were updated accordingly and transmitted to Cigna internal partners on 3/14/13. The sample claim, processed on 5/11/13, was adjudicated correctly in accordance with the revised benefit.

B. At the time the 1/7/13 and 1/18/13 service dates were processed, the provider was considered as an out of network physician and the out of network benefits (deductible) were applied accordingly. Cigna was notified of the provider's in network status through the provider extract file sent to Cigna by Allegiance mid-February 2013. The provider record was updated accordingly and the additional claims received were processed with a copayment.

CONCLUSION

A. and B. No errors, however, CTI cites an additional observation to note the processing of the sample claim falls under the updated Allergy and Injections benefit where an office setting processes at coinsurance, plan deductible waived.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130399812220130219
Audit No: 1067
Employee Relation: S
Auditor: John Spalten
Conclusion Date: 04/02/2014

OBSERVATION 1 **TO:**

A. This claim applied the entire amount to the discount (Remark 1211 - This represents your savings, etc). The pricing on the claim shows allow 100% of the billed charge - $562.00. CTI will cite an adjudication error and $462.00 underpayment.

RESPONSE 1

A. Disagree: Health Care Professional is not contracted with Allegiance. Please see 00 method code on claim submission indicating HCP is not contracted with Allegiance (not a MT provider), as such, the $562 allowance shown in pricing field is not applicable. The provider is contracted through the Idaho Phys Network, and the contracted network rate should apply. Initial reduction was incorrect. The underpayment was identified and payment of $81.90 was correctly issued within scope period on 4/15/13. Please see the attached claim showing the method code 00.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the Allegiance pricing issue.

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☑ FinAccum IDOC Primary
FinPrimary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1068
Auditor: John Spalten

Run Date: 4/25/2014 10:16:25 AM
Claim No: 46713059961562013031 3
Employee Relation: S
Conclusion Date: 04/25/2014

OBSERVATION 1 **TO:**

A. 29999 was denied with Remark Code 1005 (Benefits were reduced for failure to obtain precert, etc). Pre-certification is not required for this surgery. CTI will cite an adjudication error and $2,159.21 underpayment. CTI notes that this claim was adjusted on 4/6/13.

B. Please document that 64415 should not apply a 50% multiple surgery reduction.

C. Please document that 29999 should not apply a 50% multiple surgery reduction.

RESPONSE 1

A. Disagree. The State of Montana has elected Cigna's PHS+ Medical Management Model which requires pre-certification/medical necessity review for inpatient services along with select outpatient procedures., 29999 requires medical necessity review, please see attached. Claim was reconsidered once additional medical support/notes were provided on image 13084300070362.
B. Multiple Surgery reduction does not apply to this provider, see attached.
C. Multiple Surgery reduction does not apply to this provider, see attached.

OBSERVATION 2 **TO:**

D. Please document that 29822 does not require precertification/medical necessity review.

E. Please provide a copy of the operative report for this service.

RESPONSE 2

D. See attached documents. CTI notes that Cigna provided documentation that 29822 does not require review.

E. See attached documents. CTI notes that Cigna provided a copy of the operative report to document that both surgeries were performed although the provided did not bill for 29999.

CONCLUSION

A - E. Additional Observation Only: Cigna does not apply multiple surgery reductions to several facilities because these providers apply the reduction prior to submitting the claim. There is no indication that this provider has applied a multiple procedure reduction on this claim. The State of Montana should discuss with Cigna how to verify that these providers are applying multiple procedure reductions.

FOR CTI INTERNAL USE ONLY

☑ FinAccum FinPrimary IDOC Primary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867131689569220130625
Audit No: 1080
Employee Relation: E
Auditor: John Spalten
Conclusion Date: 04/02/2014

OBSERVATION 1 **TO:**

A. The allowance appears to be a DRG. The elimination of Revenue Code 942 would not change the DRG allowance of $10,026.69. Less the $ 2,500 Coinsurance results in a payment of $7,526.69. CTI will cite an adjudication error and $9.83 underpayment.

B. Total charges = $57561.72. Less non-covered of $30 = $57531.72 X .1742 = $10,022.02. Less the $2,500 Coinsurance results in a payment $7,522.02. CTI will cite an adjudication error and $5.16 underpayment.

C. The pricing on the claim shows a total allowed amount of $10,026.69. This appears to be a DRG amount but also equals a .8258 Discount. The pricing on the individual line items of the claim is either a 10% or 11% discount. Which is the correct discount amount?

RESPONSE 1

A. Response: Disagree= The claim level allowable sent over by Allegiance was not noted to be a drg or case rate.. Transmission issues have been observed from Allegiance where claims have been passed to Cigna with both claim level and line level pricing information, with the amounts being different. When claim level pricing is provided, Cigna has been instructed to apply the claim level pricing. Rev 942 is a non covered item, therefore the overall claim allowable that applied to this line would be not covered.

B. Claim level allowable 10,026.69 (less 5.22, the non covered 942 line) = $10021.47 less ded applied of $4.61 and coinsurance $2500.00= $7516.86 payable.

C. Disagree: Claim was processed correctly in accordance with claim level pricing provided by Allegiance. Transmission issues have been observed from Allegiance where claims have been passed to Cigna with both claim level and line level pricing information, with the amounts being different. When claim level pricing is provided, Cigna has been instructed to apply the claim level pricing. Allegiance has initiated reprocessing projects, where applicable, advising Cigna of incorrect pricing transmitted and any claims requiring additional allowance. At the time of this review, Cigna had not received any requests from Allegiance indicating the claim level pricing was incorrect.

CONCLUSION

A - C. No errors, however, CTI cites an additional observation to note the processing of the sample claim falls under the Allegiance pricing issue and Cigna has not been advised pricing as passed by Allegiance was incorrect.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867131549012020130605
Audit No: 1085
Employee Relation: E
Auditor: John Spalten
Conclusion Date: 03/27/2014

OBSERVATION 1 **TO:**

A. This claim initially paid colonoscopy @75%. Colonoscopy should be paid at 100%. CTI will cite an adjudication error and $18.69 underpayment. CTI notes that this claim was adjusted on 10/8/13 and 2/20/14.

B. Please document how the allowance for 45378 was determined. Please document if multiple procedure reduction should be applied to 45378.

RESPONSE 1

A. Disagree, the claim was billed with a non- preventive diagnosis and was first processed applying a deductible and coinsurance. The colonoscopy benefit changed to not apply the deductible and coinsurance to the member's first colonoscopy of the year regardless of diagnosis. Benefits and claim was updated within the scope to indicate the claim was covered at 100%.

B. MSR does not apply to 45378 on this claim because it is the primary procedure.

CONCLUSION

A. No errors. CTI makes an additional observation that this colonoscopy claim was adjusted to pay correct benefits within the audit period based upon benefit clarifications that "benefits for the first colonoscopy regardless of diagnosis (preventive or diagnostic) is to be covered at 100%, all subsequent services paid at place of service bounds".

B. No errors.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 467131359025620130523
Audit No: 1086
Employee Relation: D
Auditor: John Spalten
Conclusion Date: 04/02/2014

OBSERVATION 1 **TO:**

A. Dependent has other coverage with UMR. Claim not coordinated with primary carrier. CTI will cite an adjudication error and $3,840.28 overpayment. CTI notes that this claim was adjusted on 10/29/13.

RESPONSE 1

A. Disagree: Initial calculation as secondary was incorrectly made by the claim processor. The plan has selected cob type- Standard without Benefit Credit. Our liability is calculated by using the highest allowable between the two plans, then we pay the lesser of secondary plans liability or the secondary plans allowable expense minus the primary plan's payment. (Highest allowable is ours $5757.00 less what primary carrier paid of $4297.43= $1459.57 our correct payment) Incorrect payment of 4317.77 was made on 05/23/13 = $2858.20 overpaid. In review of the file, Cigna identified the overpayment and requested the refund on 7/25/13. The refund was received and posted to the claim record on 10/29/13, within the scope period. The HCP elected to refund an additional amount as an unsolicited refund based on the primary carrier's patient liability noted.

CONCLUSION

A. An adjudication error is cited with a $2,858.20 overpayment for incorrectly coordinating with the primary payor on the sample iteration of the claim. CTI notes the claim was corrected and the refund received 10/29/13.

FOR CTI INTERNAL USE ONLY ☑ FinAccum IDOC Primary
OIPO FinPrimary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
FOP	001	$2,858.20		☑	FINANCE	Financial
OIPO				☑	ADJUD	COB Adjud
CSBF					INFO	COB Information
		$2,858.20				

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130149443220130214
Audit No: 1087
Employee Relation: S
Auditor: John Spalten
Conclusion Date: 04/02/2014

OBSERVATION 1 **TO:**

A. This claim was denied for pricing.

B. Additional Observation Only: All 4 family members had an office visit on 1/2/13 for a vial infection. 2 of the claims paid with a $15 copay and 2 of the claims were applied to the deductible. Please explain why these claims paid differently.

RESPONSE 1

A. Claim was submitted to Cigna vs. Allegiance. No pricing was received with the initial submission and pricing was requested. Additional submission received with pricing and the claim paid with applicable pricing 3-20-13. (doc 8671307090118) Claim was adjudicated correctly at the time of initial processing. In March 2013 at the request of the State of Montana, an additional workflow was initiated to route claims to obtain pricing information vs denying for pricing.

B. The Health Care Professional has two billing addresses on record and included both billing addresses on claim submissions. Cigna's records reflected the street address as contracted through Allegiance and the two out of sample claims observed in history were processed correctly at the innetwork benefit level (copayment) for the street address. For the two remaining out of sample claims, the provider segment related to the PO Box was selected during processing. At the time of initial processing, Cigna's system did not reflect the PO Box as contracted and the claims were processed as out of network. The claim processor should have reviewed the provider record and as the contracted selection was available, process the claims at the in network level. The provider record for the PO Box was updated 3/25/13 to reflect contracted with Allegiance.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the Allegiance pricing issue.

B. No errors in sample, however, CTI cites an additional observation that the two claims processed using the incorrect provider address therefore causing the claims to be processed as out of network should be adjusted to pay correct benefits. Cigna should advise the State when the adjustments are completed.

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Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 822133399017520131217
Audit No: 1090
Employee Relation: D
Auditor: John Spalten
Conclusion Date: 04/21/2014

OBSERVATION 1 **TO:**

A. This claim denied 97350 with Remark 0017 (Exceed the maximum). Please document the total number of outpatient therapy visits for this member.

B. Please document if this patient is in case management

RESPONSE 1

A. Please see patient's history for claims therapy claims for 2013 to obtain the information you have requested.

B. Inpatient stays were managed by inpatient case managers. Various treatments on file also required medical necessity reviews, which were performed when appropriate. No additional opportunityes to add value through a formal case management service have surfaced for this patient.

OBSERVATION 2 **TO:**

C. History shows PT claims for 3/21, 3/28, 4/4, 4/18, 5/16, 5/30, 6/20, 6/27, 7/11, 7/26, 8/8, 9/11, 9/20, & 9/26. The 30 visit limit was not exceeded. CTI will cite an adjudication error and $360 underpayment.

D. Additional Observation Only: Cigna determined that there were no additional opportunities to add value through a formal case management program for this patient. CTI notes that this 1 year old child has multiple diagnosis requiring continued treatment and therapy. With Cigna's determination that the annual PT max had been met, there would seem to be significant opportunity to assist this patient and family with finding additional treatment options for this child.

RESPONSE 2

C. and D. Agree. Tina F

CONCLUSION

A. and B. No errors.

C. As agreed, an adjudication error remains with a $360 underpayment as the PT 30 visit maximum was not exceeded and the sample claim denied incorrectly. CTI notes the claim has been adjusted to issue correct benefits as the result of the conclusion of the audit.

D. Additional Observation Only: Cigna determined that there were no additional opportunities to add value through a formal case management program for this patient. CTI notes that this 1 year old child has multiple diagnosis requiring continued treatment and therapy. With Cigna's determination that the annual PT max had been met, there would seem to be significant opportunity to assist this patient and family with finding additional treatment options for this child.

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AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:25 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 822133399017520131217
Audit No: 1090
Employee Relation: D
Auditor: John Spalten
Conclusion Date: 04/21/2014

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
FL	003			☑	ADJUD	Policy Provisions
FUP	001	($120.00)		☑	FINANCE	Financial
FUP	002	($120.00)		☑	FINANCE	Financial
FUP	003	($120.00)		☑	FINANCE	Financial
CSBF					INFO	COB Information
		($360.00)				

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1103
Auditor: Dave Neal

Run Date: 4/25/2014 10:16:25 AM
Claim No: 867130339257220130215
Employee Relation: S
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. Allegiance Pricing issue.

RESPONSE 1

A. Allegiance Pricing issue.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the Allegiance pricing issue.

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IDOC Primary

Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 967130589748420130308
Audit No: 1106
Employee Relation: E
Auditor: Dave Neal
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. Allegiance Pricing issue.

RESPONSE 1

A. Allegiance Pricing issue.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the Allegiance pricing issue.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130579790420130227
Audit No: 1114
Employee Relation: S
Auditor: Dave Neal
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. When originally processed (sample iteration of claim on 2-26-13), two $250 copayments were applied and the remainder of the allowance applied to deductible. The claim should have been processed with a $250 copay, then 100% up to the allowed amount. An adjudication error is cited with a $909.09 underpayment. CTI notes the claim was adjusted to issue correct benefits 11-23-13

RESPONSE 1

A. Disagree. As established during the implementation discussions with the State of Montana, the benefit plan initially included copayments in addition to plan deductible for Emergency Room (ER) facility services. Cigna later received direction from the State of Montana that they wished to update the benefit plan to apply a $250 copayment only to ER services, waiving the application of deductible. Cigna's internal plan documents were updated accordingly. The claim was corrected within the scope period in accordance with the updated plan benefit.

OBSERVATION 2 **TO:**

A. Second Pass - Regardless of the State of Montana's benefit clarification, according to the data provided the sample claim took at least two $250 copayments and applied the remainder of $656.09 to deductible (and possibly copayment, but it's not really clear in the data or Cigna's system since copays and deductibles share the same field). Starting from the allowed amount of $1,156.09 minus a $250 copay minus the PPO $500 deductible leaves a benefit payable of $406.06. Agree that two $250 copayments (rev 260 and 450) were applied and that excess deductible and/or copay of $406.06 applied?

An adjudication error with a $406.06 underpayment is cited. It is noted that the claim was later adjusted to issue correct benefits within the scope.

RESPONSE 2

A. Disagree. Cigna concurs with CTI's assessment that the initial processing of the sample claim appears to have had an increased copy/deductible applied. However, as part of the emergency room reprocessing project, after additional clarification of intent with the State, all claims for ER were reviewed to ensure that they were processed correctly and updated to apply the confirmed benefit only. As this claim was identified, reviewed and adjusted as part of this process, the claim is correct within the scope period. As such, Cigna disagrees with the financial error assessed as this is related to a known and corrected matter.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the ER benefit clarification issue.

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Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867130579790420130227
Audit No: 1114
Employee Relation: S
Auditor: Dave Neal
Conclusion Date: 04/03/2014

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 967130569737520130226
Audit No: 1137
Employee Relation: E
Auditor: Dave Neal
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. The PPO $500 deductible was satisfied on the sample claim iteration. Please advise the specific reason the deductible was adjusted to be reduced by $15 and $15 was paid on 11/25/13. Thank you.

RESPONSE 1

A. Disagree. The adjustment reason was due to the accumulator project previously noted to adjust the in-network and out of network out of pocket amounts to cross accumulate. Tina F 3-27-14

OBSERVATION 2 **TO:**

A. 2nd Pass - Please clarify…this member has the Choice plan which has separate innet/outnet out-of-pocket maximums per page 24 of the 2013 Annual Change book. Page 24 indicates the Classic plan has combined innet/outnet out-of-pocket maximums. Therefore, this claim was adjusted in error as it should not have been part of the referenced benefit clarification where "Cigna completed an accumulator rebuild for the Classic Plan due to identifying cross-accumulation not in place. This created adjustments for claims over maximum". Were adjustments done in error on the Choice plan accumulators? Thank you.

RESPONSE 2

A. Disagree. Sample claim was processed correctly on sample processing date selected. Additional in-network deductible was withheld on two out of sample claims in history (9671305795269 and 9671323498420), as a result of manual processor error, resulting in excess deductible withheld. The adjustment to the sample claim and additional claims in history was the result of an accumulator review being performed on the account at that time. Cigna identified the excess deductible withheld and the adjustments were done accordingly to bring deductible back to $500 for customer.

CONCLUSION

A. No errors. CTI cites an additional observation to note the deductible on this claim was adjusted as the result of the accumulator review performed by Cigna.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1140
Auditor: Dave Neal

Run Date: 4/25/2014 10:16:26 AM
Claim No: 767130659439720130314
Employee Relation: S
Conclusion Date: 04/03/2014

OBSERVATION 1 **TO:**

A. Allegiance Pricing issue.

RESPONSE 1

A. Allegiance Pricing issue.

CONCLUSION

A. No errors, however, CTI cites an additional observation to note the initial processing of the sample claim and its subsequent adjustment falls under the Allegiance pricing issue.

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Code	Line No	Over/Under	ProvID	EEF	Error	Desc
OI					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Audit Period: 1/1/2013 - 12/31/2013
Audit No: 1149
Auditor: Dave Neal

Run Date: 4/25/2014 10:16:26 AM
Claim No: 867132059709220130802
Employee Relation: E
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. The system indicates coverage terminated 6-28-13. This results in an adjudication error and overpayment of $7,480.09.

Please document this payment and other payments made for services incurred after the termination date have not been recovered.

Below is a listing of claims with service dates after 6-28-13 (including the sample claim):

Claim Number	Paid Date	DOS	Charge	Paid	
8671318993420	20130729	20130702	$184.00	$167.66	
8671320096745	20130731	20130716	$44.00	$27.07	
8671321193191	20130731	20130726	$794.66	$556.26	
8671319396899	20130801	20130709	$51.00	$32.05	
8671320597092	20130802	20130715	$8,311.20	$7,480.09	(sample claim)
8671320696169	20130808	20130722	$44.00	$27.07	
8671321197630	20130810	20130725	$51.00	$32.05	
8671321295752	20130814	20130727	$44.00	$27.07	
8671323492920	20130823	20130819	$340.20	$238.14	
				$8587.46	

RESPONSE 1

A. Disagree. Claims were paid correctly based on the eligibility information on hand at the time of processing. Term date was not provided to Cigna until 9/6/13. Cigna's overpayment recovery vendor identified refund potential on the file, as a result of retro-termination date received, however, refund efforts are still ongoing at this time.

CONCLUSION

A. No errors. An additional observation is made to note that any claims incurred after the retro-termination date, but processed prior to receiving the retro-termination date, are in the refund recovery process. The State of Montana should be provided the status of recovery efforts on this member, plus any other recovery efforts that are ongoing.

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 867131499602920130530
Audit No: 1150
Employee Relation: E
Auditor: Dave Neal
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. Please document medical necessity for this service. Thank you.

RESPONSE 1

A. No precert or medical necessity review required, please see attached. D Pfeiffer 3/18/14

CONCLUSION

A. No errors. An additional observation is made that the sample claim falls into the benefit clarification category of Sleep Diagnostic claims are to be processed and allowed without requirement for authorization (gold card status).

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 467131029029720130618
Audit No: 1155
Employee Relation: S
Auditor: Dave Neal
Conclusion Date: 03/27/2014

OBSERVATION 1 **TO:**

A. This claim was incorrectly coordinated with the primary plan payment. The allowable by the other plan was $1,543.01 and this is the point at which the State of Montana plan should start as far as determining benefits, as well. After the primary plan made its payment, the member was responsible for $462.90 and the sample plan paid $1,056.94. An adjudication error is cited with a $594.04 overpayment.

Please also document the adjustment of the sample claim on 10-9-13 that apparently applied a refund of $1,056.94. The claim appears to be underpaid $462.90 as the result of this adjustment.

RESPONSE 1

A. disagree- the account cob type is Standard without Benefit Credit, the formula to follow for this type of cob is :
• Use the allowable of the plan that is higher to calculate Cigna's liability.
• Pay the lesser of the following:
Secondary plan's allowable expense minus the primary plan's payment or secondary plan's liability.
See attached cob calculations showing or liability after coordinating with the primary carrier is 1056.94 paid correctly 06/18/13. The provider contacted Cigna through correspondence wanting us to request a refund due to primary carrier's patient's responsibility.

CONCLUSION

A. No error. CTI makes an additional observation that Cigna's use of COB type "Standard without Benefit Credit", as in the case of the sample claim, can cause the State of Montana plan to issue secondary plan benefits in excess of the patient responsibility following the primary plan's payment. It is noted that the provider requested a refund request be made because they were paid in excess of the primary plan's patient responsibility. CTI recommends the State review the plan's COB methodology to ensure that payment made as a secondary plan does not exceed patient responsibility following a primary plan payment.

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Code	Line No	Over/Under	ProvID	EEF	Error	Desc
CS					INFO	COB Information

AUDIT OBSERVATION / RESPONSE FORM

Client: Montana State - CIGNA
Run Date: 4/25/2014 10:16:26 AM
Audit Period: 1/1/2013 - 12/31/2013
Claim No: 967130429437620130227
Audit No: 1158
Employee Relation: E
Auditor: Dave Neal
Conclusion Date: 03/20/2014

OBSERVATION 1 **TO:**

A. A refund was processed on 7-19-13 on the sample claim. Please advise the reason for the adjustment and refund. Since the $500 PPO deductible was satisfied on the sample claim and later adjusted out, was there a review and adjustment of other PPO claims for which the deductible would have applied had the sample claim never been submitted? There would be no financial impact on the sample claim as it was processed correctly, however there are potential out-of-sample financial impacts as it does not appear other claims were adjusted to have the deductible applied to them.

RESPONSE 1

A. Sample claim paid correctly on sample processing date. Please see attached for refund information. A refund was requested and received due to workmans comp being identified (please see attached). The 7-19-13 processing was the posting of the refund received, which was processed in accordance with Cigna's standard operating procedures. Claim history is not reviewed and refunds requested for claims in history to satisfy additional deductible amounts due to the adjustment. Any additional deductibles will be applied on the next eligible claim received.

CONCLUSION

A. No errors. An additional observation is made that when a refund is received and applied on a claim that took all or part of the deductible, claims history is not reviewed to determine if it should have applied to other claims. In this case, the member's $500 PPO deductible was adjusted out due to a refund received and, in effect, was no longer satisfied. The potential exists for benefits to be issued without satisfaction of meeting the deductible during the benefit year.

Exhibit C.

Administrator's Audit Observation Responses

Cigna
Response

Claim Administration Audit
Draft Report

For

State of Montana

April 2014

Executive Summary

Cigna would like to thank both Claim Technologies Incorporated (CTI) and the State of Montana for the opportunity to respond to the audit report received from CTI. CTI conducted an audit of medical claims processed by Cigna on behalf of the State of Montana at Cigna's Bourbonnais, IL service center during the week of March 17, 2014. The onsite review consisted of a statistical sample of 180 medical claims processed during the period of January 1, 2013 through December 31, 2013. CTI's audit also included an electronic screening analysis (ESAS) of claims processed during the scope period, along with a subsequent audit of 30 focused test claims from this review while onsite.

Specifically, the audit identified the following:

Statistical Sample

- 3 underpayments totaling $420.78
- 1 overpayment in the amount of $2,858.20

Cigna confirms 1 underpayment error in the amount of $360.00 from the statistical sample. Cigna's comments on each of the specific audit samples are provided in the Field Audit Summary section below. Any agreed upon underpayments were corrected with additional payments made after the onsite review.

Cigna Response to Field Audit Summary (pages 3-12):

CTI Reported Results

	Sample Results	Weighted Results
Documentation Accuracy – Financial	100%	100%
Documentation Accuracy – Frequency	100%	
Financial Accuracy	98.84%	96.91%
Accurate Payment Frequency	97.78%	
Adjudication Proficiency	99.58%	
Accurate Processing Frequency	97.78%	
Claim Turnaround- Median Average Turnaround Time for the sample	11 days	

The financial accuracy results reported by CTI were heavily influenced by a single overpayment in the amount of $360.00 associated with sample 1090. We observed the sample incorporated only $284,742.12 in paid claim amounts out of the total amount issued of $89,413,284 during the scope period. This represents less that .01% of the total dollars issued. Cigna observed the random sample did not include any claims with payments in excess of $45,224.00 and claims with payments less than $500.00 accounted for 65% of the sample. With an industry standard auditing methodology utilizing paid amounts for the stratification process rather than charge amounts, we would expect to see a larger percentage of paid dollars and/or more representation of higher dollar paid claims selected for review.

Cigna is pleased, however, that the results of this review reflect that minimal payment errors were observed. The three additional errors assessed by CTI were previously identified by Cigna and corrected during the scope period of the audit and were correct at the time of the onsite review. With the payment accurately made for the claims within the scope period, there are no additional financial impacts to the State of Montana. We find this error assessment methodology differs from the industry norm, as consistent with industry standards, if a claim has been corrected (adjusted or refunded) within the scope of the audit, the claim would be considered processed correctly or would be classified as a procedural error only as the appropriate dollar levels have been issued (or refunded).

With the minimal amount of errors observed in this review, we do not believe the weighted results of this review are indicative of Cigna's overall service performance on behalf of the State of Montana. Documentation Accuracy (Financial and Frequency) and Adjudication Proficiency are not standard measures currently utilized by Cigna when undergoing audit reviews.

In comparison, Cigna continued to meet the quarterly Performance Guarantee targets in 2013. For the State of Montana, the accuracy results are based upon a random stratified sampling 250 claim per quarter from all claims processed by the primary claim office aligned with the account during the audit period. The Cigna service team has achieved the following accuracy results throughout the same audit scope period.

CLAIM PAYMENT ACCURACY	
	Payment Accuracy
1st Qtr 2013	99.8%
2nd Qtr 2013	99.7%
3rd Qtr 2013	98.2%
4th Qtr 2013	99.5%
Full Year 2013	99.3%
Standard	98%

Cigna continues to look for ways to improve the accuracy and efficiency of claim and call handling allowing us to provide consistently high levels of service to the State of Montana and their employees. Cigna has addressed each of the agreed to errors with the individual processors, so they are educated on the correct processing going forward. The Cigna Claim Managers also meet regularly with the State of Montana processing team to provide any applicable updates or education. Cigna looks forward to meeting with the State of Montana to discuss the results of this review and share the action plan which has been developed to address the errors observed by CTI.

While CTI's findings were favorable regarding claim turn around time (TTP), Cigna does not calculate claim TTP in the same fashion. Claim turn around time information is shared by Cigna with State of Montana quarterly.

Financial, Payment and Processing Accuracy Results

Cigna confirmed one of the four financial errors assessed by CTI. Cigna respectfully disagrees with the assessment of the financial errors on samples 1015, 1039 and 1086. Correct payments for these claims were made within the audit scope period. Comments on the specific audit samples are provided below.

Sample 1015 and 1039

Cigna confirms that underpayments totaling $60.78 occurred during the initial processing of the sample claims as a result of incorrect entry of Medicare's payment information during processing. To properly calculate Cigna's standard liability to determine the benefits payable as secondary carrier, the claim processors must ensure the Medicare payment information is entered at the service line level vs. the claim level. Individual coaching and feedback have been provided to the claim processors. Both underpayment situations were identified by Cigna and corrected within the scope of the audit, prior to the onsite review. The additional payment of $4.26 for sample 1015 was issued on November 12, 2013. The additional payment of $56.52 for sample 1039 was issued on May 20, 2013. There are no additional financial impacts to the State of Montana on these claims at this time.

Sample 1086

Cigna confirms that an overpayment in the amount of $2,858.20 occurred during the initial processing of sample claim 1086 as a result of an incorrect calculation by the claim processor. However, the overpayment had already been identified by Cigna and a request for the refund was generated on July 25, 2013. The refund was received and posted to the claim record and credited to the State of Montana on October 29, 2013, prior to the onsite review. There is no additional financial impact to the State of Montana on this claim at this time. Individual coaching and feedback have been provided to the claim processor.

Sample 1090

Cigna confirms an underpayment in the amount of $360.00 as assessed by CTI for the sample claim. The claim processor incorrectly denied an eligible service. Individual coaching and feedback have been provided to the claim processor. The claim was sent for correction and issuance of additional payment at the conclusion of the audit.

Field Audit - Additional Observations (page 13-14)

Cigna has reviewed the additional observations noted by CTI in connection with the random review. The majority of the observations provide confirmation of corrective actions Cigna completed during the scope period in accordance with various benefit clarification initiatives performed in partnership with the State of Montana to ensure claims are being adjudicated accurately per the State's intent. Additional commentary on several of the specific audit samples is provided below.

- Samples 1002, 1067, 1080, 1087, 1103, 1106 and 1140 – On behalf of the State of Montana, throughout 2013, Cigna partnered closely with the Allegiance network to improve the overall repricing process for the State's claims. In March 2013

Cigna instituted a process to obtain pricing from Allegiance when pricing was not included on the claim submission received from the contracted Health Care Professional. The majority of the claims associated with CTI's observations were initially processed during the first quarter 2013.

- Sample 1068 – The sample claim was processed in accordance with the contract pricing information received from Allegiance. In the case of the specific Health Care Professional, Cigna has received direction that no further multiple surgical reductions should be applied during processing in accordance with the Health Care Professional's contract.
- Sample 1149 – The initial processing of the sample claim, as well as the out-of-sample claims observed by CTI, was correct based on the eligibility information presented to Cigna at the time of payment. The termination date for the customer was retroactively provided to Cigna after the claims were processed. Cigna would be happy to review timely submission guidelines for eligibility termination with the State of Montana to identify areas of improvement as warranted. Cigna understands that even a short time span of retroactive terminations can create an overpayment situation. Any opportunity to shorten the eligibility notification processes will only help reduce the impacts to claim payments. Cigna identified the overpayments as a result of the updated termination date received and recovery efforts were initiated. Overpayment recovery efforts remain active at this time.
- Sample 1155 – The State of Montana has elected the Standard COB without Benefit Credit coordination provision. During the onsite review, Cigna provided the auditor with a copy of our Standard Operating Procedure (SOP) outlining the calculation of allowances for plans with Standard COB. In accordance with our SOP, the allowance is based on the greatest/higher amount allowed between the Primary carrier's Maximum Reimbursable Charge (MRC)/negotiated rate **OR** Cigna's or Allegiance's MRC/negotiated rate. Cigna will pay the lesser of our original liability and the coordination amount. For Cigna or Allegiance contracted health care professionals (HCP), we are bound by the terms of the contract between with our HCP and are obligated to honor the rates under the contract. The claim was correctly adjudicated in accordance with State of Montana's COB election; the health care professional's contracted rates and Cigna's standard operating procedures. Cigna would be happy to further review the COB provision election with the State of Montana to ensure the election in place meets their intent.
- Sample 1158 – A refund was received for the sample claim submission. Upon receipt, the refund was applied to the claim record, which credited the payment back to the State of Montana. When refunds are received, for a claim with deductible applied, Cigna's Standard Operating Procedures do not include determining other claims paid in history which could now be subject to deductible as a result of the refund being received, which reduced the amount accumulated towards the patient's annual deductible maximum. In our experience, the deductible will often be re-satisfied on new claim submissions as the deductible maximum will no longer reflect having been satisfied. Cigna would be happy to discuss the refund application process with the State of Montana.

Cigna would be happy to discuss the additional observation topic with the State of Montana if they have any questions.

Cigna Response to ESAS Summary (pages 1-16):

In order to fully audit a claim for payment accuracy, we maintain that an on-site audit is required to review the hard copy sample claim against our claim processing system, internal procedures and provider contract information. Cigna's claim payment system contains payment details that cannot be captured in an electronic file. As a result Cigna does not support electronic analysis reviews. However, as CTI agrees to perform an onsite review for a selection of claims identified from their electronic analysis; we have continued to partner with CTI on the review of the targeted selections onsite. Cigna is pleased with CTI's finding that there were no procedural deficiencies observed for all but one of the thirty ESAS targeted claim selections reviewed. We continue to look for ways to improve the accuracy and efficiency of claim and call handling allowing us to provide consistently high levels of service to the State of Montana and their employees.

I. **Duplicates**

Cigna is pleased no duplicate payment deficiencies were observed during the onsite review. Cigna has in place a thorough duplicate claim review process. Cigna's claim systems have built in logic within the system which provides a flag to the processor when a potentially duplicate claim is presented for processing. The most frequently identified are "Exact" duplicates or "Possible" duplicates. The system will compare the provider name, date of service, type of service and charges to flag for duplicate services. These edits alert Claim Processors that duplicate services may have been received and further investigation is necessary.

In Addition to our claim system edits, Cigna's National Overpayment Identification Team (NOIT) receives and reviews Cigna's paid claim data each week, using proprietary queries and edits, to identify potential overpayments. Cigna also partners with several specialized vendors to identify and collect overpayments not identified within our baseline programs.

Between our pre-payment edits, and post-payment review processes, Cigna has established controls to minimize duplicate payments and capture incorrect payments issued.

II. **Denial of Mandated Benefits**

Cigna provides coverage for Breast Reconstruction services following a mastectomy in accordance with the Women's Health and Cancer Rights Acts. Breast Reconstruction procedures are on Cigna's list of services requiring pre-authorization or medical necessity review, as the services can be performed for reasons other than post-mastectomy care. Cigna maintains a listing of services requiring pre-certification and/or medical review, making updates as warranted. The information is published on our website for reference by health care professionals.

In the ESAS sample reviewed, sample 19, pre-authorization was not obtained resulting in the denial of the claim as not being pre-authorized. The claim was processed in accordance with Cigna standard operating procedures. In this situation, medical records may be provided to support the medical necessity for the procedure and the claim may be reprocessed and allowed upon review. Cigna stands by the initial denial of the claim based on lack of the necessary pre-authorization. Upon receipt of additional supporting documentation and completion of medical review, the service was authorized and processed accordingly on January 15, 2014. During the review process, if medical records support that the reconstruction performed is the result of cancer surgery, the services would be approved and processed, which would be in compliance with the Women's Health and Cancer Rights Act.

Cigna Response to Operational Review

In conjunction with the audit project, Cigna was asked to complete an Operational Review Questionnaire prior to the onsite audit. The Operational Review report presents CTI's general observations and recommendations based on their analysis of the material. Cigna would be happy to discuss any questions State of Montana may have as a result of the operational review and the findings or recommendations noted by CTI.